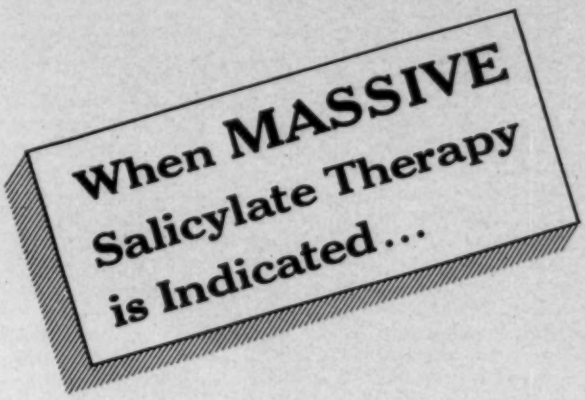

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Between Ourselves

Probably the most indefatigable workers for nursing in Canada are the **Executive Secretaries of the nine provincial associations and our General Secretary.** They don't know that such a thing as an eight-hour day came into vogue for the nursing profession years ago! After a full day at their respective offices—handling mountains of correspondence; interviewing nurses, young and old; guiding, counselling, planning—they tear off to evening meetings or lug home a briefcase crammed with reports to be digested or new material to be sorted out and written up. A gallant, interested, hard-working, loyal group! We feel that it is particularly fitting, therefore, that our New Year's editorial page should be theirs. They bring cordial greetings and inspiration to us all.

* * *

When one of Canada's most outstanding women, **Dr. Charlotte Whitton,** is advertised as the guest speaker on any occasion, her eager listeners know that they will receive food for thought that will have a very tonic effect. Dr. Whitton participated in a special refresher course at the University of Toronto School of Nursing last October. The nurses who listened to her masterly summation of present-day trends received a very real challenge to dig in and find plausible answers to our problems. "If the profession fails to meet and master it, solution will come from others, for neither the mood nor patience of the present times brooks much loitering." Dr. Whitton is not a nurse nor a medical woman but her insight into the difficulties of today give her words an authoritative ring that we of the nursing profession must not evade. We are very grateful for the permission to publish this address in full so that all of our readers may square off and face the challenge with an intelligent understanding of the implications.

* * *

A propos of nurses being well-informed on their professional affairs, we were interested to read one of the remarks made by Dr. L. J. Piccoli, professor of pharmacology, Fordham University, at a dinner meeting of pharmacists in Montreal. Dr. Piccoli states: "To keep abreast of the latest developments in pharmacy, it is necessary for the pharmacist to follow the professional literature and to have available—properly classified—information that he thinks may be of possible future value."

We feel very strongly that the same thing applies to nurses. Yet with some 30,000 graduate nurses in active practice in Canada, less than 9,000 are personal subscribers to their professional *Journal.* How are the others keeping "abreast of the latest developments"? Or are they?

* * *

One of our recent authors, in acknowledging the complimentary copies of *The Canadian Nurse* sent to him, said: "Would it be considered an impertinence if I raised my eyebrows at the inclusion in a professional journal of the reading time of the articles? I always thought this was for people who moved their lips when they read the comics!"

Perhaps he is right. We have received some favorable comments on this practice, however. It certainly is an answer to the folk who tell us they "haven't time to read *The Canadian Nurse.*" For example, the total time for all the articles so marked in the December issue came to 1 hour, 43 minutes, and 42 seconds!

* * *

The publication of the questions and answers contained in the **Fact Sheet on Labor Relations,** which was developed by the Registered Nurses' Association of British Columbia, follows the suggestion of their Labor Relations Committee. It is not intended as a lure to attract nurses to that province. Rather, it is a recognition of the fact that the R.N.A.B.C. has come to grips with some of the problems confronting members of the profession in a realistic, mid-twentieth-century fashion. Copies of the printed leaflet were mailed to each member of the association for their information and guidance. The Labor Relations Committee is proud of the accord it has established and rightly so.

* * *

Fresh as tomorrow's news, the bright wee daughter of Dr. and Mrs. W. Gordon Townsend, Calgary, greets you all with a happy smile on **our cover.**

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Note: The adequately prepared nurse has one unique qualification for service in the field of mental health, namely, prolonged *clinical experience* resulting in certain knowledge and understanding that can be gained in no other way. Hence, a first step in preparing nurses for future work in this whole field must include clinical experience in the psychiatric hospital.

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(b) Principles and methods in classroom and clinical teaching.

(c) Developments in nursing education.

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University of Toronto,
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ARTANE TABLETS

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Description—2 mg. and 5 mg. tablets of Artane trihexyphenidyl (Lederle brand of 3-(1-peridyl-)-1-phenyl-1-cyclohexyl-1-propanol hydrochloride).

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THEPHORIN LOTION

Manufacturer—Hoffmann-La Roche Limited, Montreal.

Description—A flesh-colored, hypo-allergenic, non-staining, emollient lotion containing 5% Thephorin (2-methyl-9 phenyl-2, 3, 4, 9-tetrahydro-1-pyridindene).

Indications—Is of value in relieving allergic skin manifestations; pruritic dematoses; sunburn and insect bites.

FENSOBAR Powder, Tablets, Liquid

Manufacturer—U.S. Vitamin Corporation; Canadian distributor: Saville Rolls Limited, Toronto.

Description—Each level teaspoonful of powder or teaspoonful of liquid or each tablet provides:

	Powder	Liquid or Tablets
Extract of belladonna	5.9 mg.	5.9 mg.
Phenobarbitone	16.2 mg.	16.2 mg.
Aluminum hydroxide	140.0 mg.	126.0 mg.
Magnesium trisilicate	140.0 mg.	126.0 mg.
Bismuth subcarbonate	73.0 mg.	65.0 mg.
Magnesium carbonate	560.0 mg.	504.0 mg.
Sodium bicarbonate	452.0 mg.	4.07 mg.
Essence of peppermint	7.0 mg.	6.0 mg.
Malt diastase	28.0 mg.	25.0 mg.

(Fensobar Liquid contains 0.25 cc. Tincture of Belladonna and 3.33 cc. Elixir of Phenobarbitone per teaspoonful.)

Indications—Peptic ulcer; gastric hyperacidity; dyspepsia; flatulence; certain types of gastritis; jylorospasm; distress due to excesses of alcohol, tobacco, and eating. Also of value in preventing distress of motion sickness and vomiting of pregnancy.

Important New Editions!

PROFESSIONAL TRENDS AND ADJUSTMENTS IN NURSING: *by Eugenia Kennedy Spalding, R.N., M.A., Professor of Nursing Education, Indiana University, Bloomington, Indiana.*

NEW 4th EDITION

This new, 4th edition of the book "Professional Adjustments in Nursing" reflects changes within recent years in social, economic and political developments as they relate to professional nursing problems. Extensive revisions are made throughout the text. Historical phases are discussed with greater emphasis on contemporary and possible future influences on nursing in all its aspects—amplifying the text as in no other previous edition of this outstanding guide. Some of the greatest changes can be noted in the chapters on "Nursing in the Present Situation" and "Nurses in Public Service," and there is an entirely new chapter with additional information on national nursing and allied organizations. A select list of references is given, with suggestions on where to find current pertinent materials. In Active Preparation.

HISTORY OF NURSING NOTEBOOK: *by Elizabeth M. Jamieson, B.A., R.N., Late Instructor, Lakeside Hospital, Cleveland, Ohio; and Mary F. Sewall, B.S., R.N., Director of Nursing Education, Methodist Hospital of Southern California, Los Angeles.*

NEW 9th EDITION

Revisions are made throughout the text in the new, 9th edition of this presentation in card outline form of the eras of the world's history influencing the growth of nursing. References are elaborated and brought up to date. Entirely new for this edition are review questions of interest and assistance in study and lesson planning. As in previous editions, each card contains a preliminary survey of a phase of nursing development which can be enlarged upon at the discretion of the instructor. Buff cards represent periods of development; blue, periods of deterioration; salmon, periods during wars; white, other phases of nursing history. Five outline maps to be filled in by students are again provided. 40 cards. In Active Preparation.

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Manufacturer—G. D. Searle & Co., Chicago.

Description—Each scored tablet contains 100 mg. of beta-dimethylaminoethyl benzohydryl ether-8-chloro-theophyllinate.

Indications—For prevention and treatment of seasickness. May also be equally effective for other types of motion sickness.

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Manufacturer—Anglo-Canadian Drug Co. Ltd., Oshawa, Ontario.

Description—Each tablet contains 5 mg. of Anca brand of d-desoxyephedrine.

Indications—Depressive states, as: simple depression of old age, depression attending protracted post-operative recovery or accompanying chronic organic disease, depression precipitated by the menopause. Also in treatment of obesity.

QUADRONAL TABLETS

Manufacturer—E. Bilhuber, Inc.; Canadian distributor: Merck & Co. Ltd., Montreal.

Description—Each tablet contains

Ephedrine hydrochloride	⅜ gr.
Phenobarbitone	⅜ gr.
Phyllicin (theophylline-calcium salicylate)	2 gr.
Potassium iodide	5 gr.

Indications—Prevention of asthma and relief of moderately severe attacks. Contraindicated in tuberculosis, hyperthyroidism, hypertension, heart disease, and diabetes. Frequent or continued use may cause nervousness, restlessness, sleeplessness.

DOMEBORO TABS POWDER

Manufacturer—Dome Chemical, Inc.; Canadian distributor: Saville Rolls Limited, Toronto.

Description—Each powder packet contains a total of 2.2 grams of aluminum sulphate and calcium acetate, to produce, when dissolved in one quart of warm tap water, a lead-free, stable, 1:40 Burow's solution, pH 4.2.

Indications—Acid douche for feminine hygiene; adjuvant therapy in vaginitis and trichomonas vaginalis.

BACIGUENT, Ointment

Manufacturer—The Upjohn Company, Toronto.

Description—Each gm. contains 500 units of antibacterial agent, Bacitracin, in a non-irritating, neutral ointment base.

Indications—The treatment of superficial infections of the skin caused by organisms susceptible to Bacitracin.

Administration—Apply locally, with or without a bandage, one or more times a day as required. For deep infections, Bacitracin-Topical should be given by local injections. If sensitization occurs, discontinue use.

BACITRACIN—Topical

Manufacturer—The Upjohn Company, Toronto.

Description—Sterile powder for preparation of wet dressings, irrigations, and local instillation. Each 25 cc. vial contains 2,000 units or 10,000 units of Bacitracin.

Indications—Infections of the skin due to organisms susceptible to Bacitracin.

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Manufacturer—Hoffmann-La Roche Limited, Montreal.

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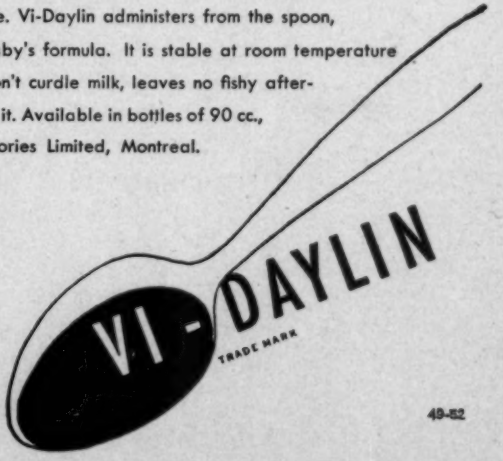

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX *NUMBER ONE*

MONTREAL, JANUARY, 1950

New Year Greetings

"The past is inspiring, the future is challenging, the present is our responsibility." In these words, Miss Daisy Bridges conveyed to the delegates and members present at the recent Interim Conference of the International Council of Nurses in Sweden a message of vital significance to the nurses of the world.

The present is *our* responsibility . . . What food for thought this gives, especially as we enter upon a new year. Already there are signs that the apathy which has characterized the weary post-war world is being replaced by a renewed vitality and spiritual rebirth in almost all lines of human endeavor. Interesting new developments are beginning to manifest themselves in nursing. Your professional *Journal* in the coming months will bring you news of these developments. It will be important for the nurses of Canada not only to familiarize themselves with current trends, but also to participate individually and collectively in translating these from dreams to realities. A few valiant nursing leaders shaped the inspiring past. We cannot continue any longer to expect a few devoted souls to carry the whole burden of responsibility for shaping the present and the future of our profession.

It is confidently expected that the nurses of Canada will not be found wanting when they are called upon to share in the manifold tasks which lie ahead.

Gertrude M. Hall.

General Secretary, Canadian Nurses' Association

On behalf of the Alberta Association of Registered Nurses I wish to extend to all nurses in Canada our most sincere wishes for 1950. 1949 found us at the crossroads in nursing. Will 1950 pave the way to a brighter tomorrow? Only with the full co-operation and whole-hearted support of not the few

but the whole of our nursing group can we progress in the right direction. The past is but a reflection of our future achievements.

Clara A. Van Dusen

Registrar, Alberta Association of Registered Nurses

British Columbia nurses extend New Year greetings to all nurses east of the Rockies. We are busy and excited in our preparations for the role of hostess province for the biennial next June. We shall have the totem poles polished and the mountains all spruced up for our guests.

Alexia L. Wright

Executive Secretary
Registered Nurses' Association of British Columbia

As my New Year message, I would like to quote from "The Mature Mind" by H. A. Overstreet:

> It will mean much to our confused and hostility ridden world if and when the conviction begins to dawn that the people we call "bad" are people we should call immature. This conviction would bring us to the realization of what needs to be done if our world is to be rescued from its many defects. The chief job of our culture is, then, to help all people to grow up . . . While his torturers were making his last hours more terrible than they needed to have been by adding cruelty to cruelty, Christ prayed: "Father forgive them, for they know not what they do." He saw them not as "bad" but rather as too ungrown-up even to know that their cruelty was cruelty. It is this insight—that the evil men do is the evil of their immaturity—that may yet save the world.

May this conviction and this insight guide Canadian nurses individually and collectively in 1950 and henceforth.

Lillian E. Pettigrew

Executive Secretary and Registrar
Manitoba Association of Registered Nurses

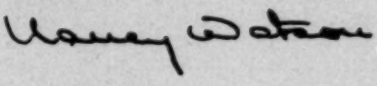
We welcome the privilege of extending a greeting to the nurses of Canada through *The Canadian Nurse*. I am pleased to join with the other provincial executive secretaries in wishing you all much happiness and success in your many endeavors through 1950.

Velma F. Law

Executive Secretary
New Brunswick Association of Registered Nurses

I wish on behalf of the Registered Nurses' Association of Nova Scotia to extend to all nurses throughout Canada our warmest greetings and best wishes. It is our sincere hope that the coming year may witness continued progress

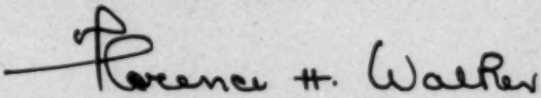
in our profession, and bring to all of us a deeper appreciation of our opportunities for service.



Secretary-Registrar
Registered Nurses' Association of Nova Scotia

This year is the halfway mark of the twentieth century and the twenty-fifth anniversary year of the Registered Nurses' Association of Ontario. For Ontario nurses in particular it should be a year of stock-taking, when past achievements are evaluated; and of constructive planning, when future goals are set.

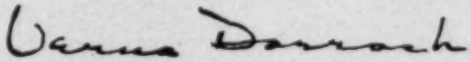
We greet Canadian nurses from British Columbia to Newfoundland and offer sincere good wishes to our sister provincial associations for a year of progress in meeting the very real problems which confront us all.



Secretary-Treasurer
Registered Nurses' Association of Ontario

A New Year is opening and it is a time to extend greetings. The Association of Nurses of Prince Edward Island looks forward to the New Year with courage and confidence. If we can feel this confidence when things about us are full of difficulties, it is because you, the members, are with us, ready to support and advance provincial and national projects.

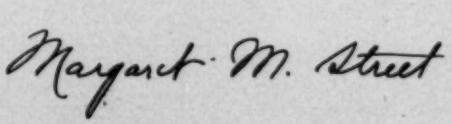
To each of you, and to all nurses we extend that old wish—a Happy New Year.



Secretary
The Association of Nurses of Prince Edward Island

One of the foremost leaders of Canadian nursing recently made a strong appeal that the nurses of Canada should go forward with a strong faith that obstacles would be overcome and goals achieved. This clarion-call will echo and re-echo in our minds and spirits as we enter the new year.

Faith and courage of the highest order will indeed be required if we are to accept the challenge of the future and play our full part in modern nursing developments. However, as "faith without works is dead," our faith must be accompanied by strong and concerted efforts in the interests of better care of patients through better preparation of nursing and of auxiliary nursing personnel.



Secretary-Registrar
The Association of Nurses of the Province of Quebec

In these days, renewed courage is needed to face the future. "Go out

into the darkness and put your hand into the Hand of God . . . " thus comes strength and courage.

All of us have rosy dreams and build fairy castles. Noble dreams and aspirations are not to be despised though in reality they must be disciplined to possibilities. We must walk straight into the tasks we can do while we keep our feet firmly on the ground. The accomplishment of each task should make a goal in our individual plan for creative achievement.

Lola Wilson

Assistant Registrar
Saskatchewan Registered Nurses' Association

In the Good Old Days

(The Canadian Nurse, January 1910)

"On the first day of December, 1884, Miss Mary Agnes Snively, a Canadian who had graduated from the Training School for Nurses at Bellevue Hospital, (New York), entered on her duties as Superintendent of the Training School for Nurses at Toronto General Hospital, a position of honor, trust and arduous labor which she has held ever since, to the advantage of the hospital, the profession and the community.

"On the first day of December, 1909, the twenty-fifth anniversary of her appointment, a great company of the Board of Governors, the Staff of the hospital, household, the citizens of Toronto and, above all, the nurses, a large representation of the five hundred and more trained under her, assembled in the Nurses' Residence to offer congratulations and do her honor.

"The most dramatic moment of a memorable evening arrived, when Mr. Flavelle made the impressive and unexpected announcement of Miss Snively's retirement . . . the Board of Governors had decided to present Miss Snively with a retiring allowance of $700 during her lifetime."

* * *

"The most interesting feature of my post-graduate course has been the high caloric diet in typhoid fever. I could not believe it possible that the trays of toast, eggs, milk, cream and junket were actually being taken in to typhoid patients who were running high temperatures. Visions of hemorrhages, perforations and kindred ills kept flitting through my head but I soon found that the patients looked bright and happy and were actually gaining weight . . . Some took as many as 6,500 calories a day.

* * *

"A nurse comes in contact continually with ill health, pain, suffering, worry, anxiety, sorrow and death. In order to preserve her own mental and physical health and poise she should have recreation. She should make a special point of taking up some interest apart from her work as a nurse . . . To be familiar with current literature and to read aloud agreeably, to be willing to join in a hand of whist, to take part in a dance, to be able to wield, even with poor effect, a racket or mallet, are small matters with an actual place in life. The nurse should be encouraged, in order to preserve a happy balance, to be at times extremely frivolous, even wildly gay."

How cold should smallpox vaccine be kept? The colder the better; well below freezing if possible. Icebox refrigeration is not cold enough for this purpose. Smallpox vaccine cannot be injured by freezing, as can serums and other vaccines. Even a single day out of cold storage may produce detectable deterioration in potency.

In an electric refrigerator the smallpox vaccine should be kept in an ice-making compartment.

—U.S. Public Health Reports

Injuries to Bones and Joints

DONALD WHYTE, M.D., F.R.C.S. (EDIN.)

Average reading time — 12 min. 48 sec.

THE PURPOSE of this article is mainly to review the subject of fractures and to outline the objects of treatment and the methods now in use to secure these objects. However, it may not be amiss to first scan briefly the injuries that may occur to muscles, ligaments, and joints by trauma similar to that which causes fractures.

STRAINS

A strain is an injury to muscles or ligaments due to overuse. This overuse may be within the normal range but too long continued or it may be a single effort of too great a violence. An instance of the first type is the sore muscles and/or ligaments which follow taking exercise to which one is not accustomed. An example of the second is the sore back one may have after one single big effort to lift something too heavy for one's strength. Many so-called minor sprains of the ankle would be better termed "strains." Strains recover best with heat, massage, and active movements within the normal range.

SPRAINS

A sprain is a partial or complete rupture of one or more ligaments of a joint without dislocation of the joint. As some tissue has been actually torn or separated, that tissue needs complete rest and protection for a period long enough to allow it to reunite. Most sprains are best treated by immobilization in plaster of paris but, for some of the less severe ones, protection by adequate adhesive strapping may be sufficient. The final results of severe sprains of the ankle are generally much better if the patient's foot and leg is put in a plaster cast with a walking device attached or incorporated in it.

Dr. Whyte practises in Peterborough, Ont.

SUBLUXATIONS

A subluxation or a sub-dislocation is a momentary partial or complete dislocation which reduces itself immediately, leaving a very severe degree of ligament damage. The diagnosis is an assumed one when one can show clinically or under x-ray that the partial or complete dislocation can be easily repeated, without using force. This can only be done with the patient under general anesthetic or the affected joint rendered completely painless by local anesthesia. This test is very worthwhile for it enables one to assess the severity of the ligamentous and soft tissue damage and so estimate more correctly the length of time the joint must be immobilized.

Subluxations of the ankle are fairly common but the diagnosis is often missed because this test is not applied. These injuries, in the case of the ankle, need 7 or 8 weeks of complete immobilization in a walking plaster of paris cast.

DISLOCATION

A dislocation is the displacement of a bone at a joint so that it no longer occupies its normal position in relation to the other bone (or bones) of this joint. Of necessity, there must be a great deal of associated damage to ligaments and other soft tissues in the region of the dislocated joint. The treatment is to reduce the dislocation and then protect the damaged ligaments by immobilization in plaster of paris for 8 to 12 weeks.

FRACTURES

A fracture is a break in the continuity of a bone. Fractures are classified in two ways:

A—as regards the *damage done to the bone itself:*

1. *Greenstick* — a break part way through the bone of a child with the rest of the bone at that level bending instead of breaking.

2. *Simple*—the break may be transverse or oblique or spiral but it is a single line of fracture giving two fragments only.

3. *Comminuted*—there are several lines of fracture resulting in three or more fragments.

4. *Impacted*—after the bone has fractured some force has caused the broken ends to become jambed together giving a certain amount of stability at the fracture site.

B—as regards the *damage done to surrounding soft tissues* in the region of the fracture:

1. *Simple*—when there is minimal soft tissue damage.

2. *Compound*—when the skin over or near the fracture has been broken, either from within or from without, enabling the fracture to be exposed to the outside world and, therefore, in danger of becoming infected.

3. *Complicated*—when important structures, such as large blood vessels or nerves, near the fracture have been damaged.

Diagnostic Clues

With the availability of x-ray machines and the great tendency to x-ray all injuries, clinical diagnosis of fractures has almost ceased to be an art. Nevertheless, we shall consider briefly the more important points leading to a clinical diagnosis of fracture:

1. *Pain:* Usually severe at rest and intense if the part is moved.

2. *Tenderness:* Well localized over the site of fracture.

3. *Deformity:* Not always present but when it is present, it is excellent evidence.

4. *Unnatural mobility:* If a limb moves, or can be moved, at a place where no joint normally exists then it must be fractured.

5. *Crepitation:* A sign not to be deliberately sought but if noted on accidental moving of the part it is conclusive evidence.

Small bones, like those in the wrist and ankle, may sustain a crack fracture which does not show on an early x-ray but, if re-x-rayed 10 days later, enough absorption will have occurred around the crack so that it will show.

Treatment of Fractures

The object of the treatment is to return the bone as nearly as possible to its original shape and length and to hold it in this position as long as necessary to get union. However, the greater objective, and one often forgotten, is to restore the injured part to health with the least possible disability. In order to obtain this latter goal one may have to:

1. Be satisfied with a relatively poor reduction rather than do irreparable damage to soft tissues in an heroic attempt to get a beautiful x-ray reduction.

2. Reduce (even sometimes to zero) the period of immobilization in order to avoid, as in the aged, permanently "frozen" joints on one or both sides of the fracture. If this occurs an excellent reduction and solid union are meaningless to the patient.

Reduction: To reduce a fracture we must overcome first, the shortening, and second, the deformity which is due to angulation and/or rotation.

Immobilization: During the period of immobilization we must try to maintain first, the proper length and second, the proper alignment of the fragments.

In the majority of fractures the reduction can only be done with the aid of an anesthetic—general, spinal, or local—in order to render the manoeuvre painless to the patient and to relax his muscles so that shortening may be overcome.

Methods of Obtaining Reduction

1. *Manual:* By merely taking hold of the limb with one hand above and one below the fracture and manipulating the parts into their normal positions.

2. *Traction:* In doing a reduction manually one uses traction also, but, under this heading, I refer to traction of a greater degree applied by some mechanical means. This traction may be applied for a few minutes only, while some method of immobilization is being applied, or it may be continued in some degree for the duration of the treatment and it then becomes part of the process of immobilization.

Screws, turnbuckles, or weights are

used to mechanically increase the strength of this traction. The traction power may be transferred to the limb by means of adhesive fastened to the skin or by a metallic device into or through the bone. This latter is referred to as *Skeletal Traction*.

There are many types of apparatus used for applying skeletal traction. Some of these are:

1. Ice-tong calipers.
2. Steinmann pins.
3. Kirschner wires.
4. Roger Anderson apparatus.
5. Stader splint.

Steinmann pins are a lot larger than Kirschner wires but they have the advantage of being stationery in the bone as they do not rotate or slide backwards and forwards. This probably reduces the incidence of infection around the pin or wire.

The last two are similar in principle as each is a mechanical reduction-immobilization machine. By means of two metal pins in each fragment the machine obtains length and alignment and then maintains this reduction until union occurs.

Methods of Immobilization

1. *Splints:* Wood, metal, adhesive. These are useful in a few types of fractures. Adhesive strapping is the only practical means of splinting fractured ribs.

2. *Plaster of paris:* This is the finest of all splints because each plaster splint is tailor-made to fit the particular limb being treated. Some further comments about the use of plaster will be made later.

3. *Continuous traction:* Skin or skeletal. The same traction which is used to obtain reduction is often used continuously during treatment as a means of, or an aid in, maintaining reduction. The pull maintains the length which might otherwise be lost and the muscles surrounding the fractured bone, being kept taut by this traction, act as splints. This method of immobilization has many methods of application. Its one danger is that the bone ends may become separated at the fracture site and so delay union.

The Roger Anderson and Stader machines may be included in this group, but their side bars act as splints as well as maintaining continuous traction.

4. *Internal fixation:* This means that the fracture site is exposed by an open operation and, when reduction has been obtained, the fragments are held in position by some mechanical means applied directly to the bone. The "mechanical means" is usually metallic in nature but could be a bone graft. While a bone graft may help to maintain reduction, its main purpose is usually to improve bony union in a case of delayed or non-union. The metallic objects may be screws alone, or metal plates, or Kuntscher pins or Kirschner wires driven down the medullary cavity, or Smith-Petersen nails as in fractures of the hip. Each of these methods has its place and in that place is extremely useful, but one must always take into consideration the fact that, in the case of a closed fracture, one has to convert it into a compound fracture in order to use these methods. One, therefore, exposes the patient to the slight but real risk of osteomyelitis.

In all cases treated by continuous traction or by internal fixation of the fracture there is one potential complication of great importance. This is called *distraction*. Any separation between the fractured ends of a bone greatly delays healing and in some bones, where the blood supply is poor, a slight amount of separation or distraction may lead to non-union. This is especially true at the junction of the middle and lower thirds of the tibia. This separation may not be present when the reduction and fixation is completed but may occur later due to absorption of bone along each side of the fracture line. The rigid immobilization then prevents the fragments from being approximated by muscle pull and an area of separation persists.

Plaster of Paris

Plaster may be applied padded, unpadded, or partially padded. If no swelling follows the application

of the plaster the unpadded cast no doubt gives the best immobilization. Small amounts of rubber or felt over those bony prominences which lie close under the skin probably add to the patient's comfort without appreciably detracting from the immobilization.

Early swelling following the application of plaster of paris is the main complication and is one for which the nurse should always be on the lookout. If it proceeds to the point of interfering with the blood supply to the limb, amputation may become unavoidable. The nurse can help to avoid this most unfortunate complication by frequently looking at and feeling the toes and fingers which stick out beyond the end of the cast. The danger signs are coldness, blueness, numbness, and inability to move the digits.

The surgeon can do two things to avoid this complication:

1. Split all casts as soon as applied if he thinks swelling of a severe degree is likely to occur.
2. Elevate, for the first few days, all limbs in plaster of paris.

Walking Devices

Many fractures at or near the ankle or in the foot do better if the patient uses the limb while encased in plaster of paris. To make this possible many devices are added to the cast:

1. Plaster heels are built on to the cast or pieces of a rubber tire incorporated into it to act as a heel or rocker.
2. The walking iron is the most commonly used device but it is by no means the best. It is rare to see a patient wearing a walking iron who walks normally with it. The great tendency is to rotate the whole leg on the iron as a pivot rather than to flex the knee and walk straight ahead. Weeks after the removal of the plaster some of these people still walk with a rotating movement of the leg.
3. The wooden rocker, incorporated into the sole of the plaster, is a very satisfactory walking apparatus. It is easy and cheap to make and the patient walks with a normal movement.
4. A special boot is one of the neatest and most practical walking arrangements. It is a heavy leather boot (I use army boots) two sizes larger than the patient's correct shoe size, which is split down the front of the toe to enable it to open widely. To the sole is added a fairly thick leather metatarsal bar which is placed farther back than the usual metatarsal bar. This bar acts as a rocker. Wearing this boot, and a similar but smaller one on the well foot, a workman is able to carry on with his usual work with the fact that he is wearing a cast practically unnoticed. In some factories men are allowed to return to work wearing one of these boots when they are not allowed to work wearing a rocker or walking iron. This boot has its limitations, as the idea of wearing a big black boot, and similar footwear on the other foot, cannot be "sold" to female patients.

This is only a quick and concentrated review of injuries to bones and joints and it is, therefore, full of generalities, none of which can be taken at full face value for all injuries. It may serve, however, as a review for those whose daily work does not bring them into close contact with this branch of surgery.

A Matter of Pride

Canadian nurses take pride in their interest in international nursing affairs. More than a hundred attended the recent I.C.N. Conference in Stockholm. And yet, Miss Daisy Bridges, executive secretary of the I.C.N., wrote us recently regarding the distribution of *The International Nursing Bulletin* in Canada. She said, "We only have at present 67 subscribers in Canada. We have just deleted the names of 59 Canadian subscribers who have not paid their subscriptions, in spite of reminders, since 1947." Two years overdue!

Sixty-seven subscribers in Canada! We were shocked. We wonder how the remaining 59 feel about receiving the *Bulletin* for two years free? When we consider that the subscription rate is only **One Dollar per Year,** maybe we should all feel pretty small about that insignificant 67.

Send your subscriptions in right away to: *The International Nursing Bulletin, 19 Queen's Gate, London S.W.7, England.*

Plasters and Splints

E. Down

Average reading time — 9 min. 36 sec.

Ever since mankind has lived on the earth, there have been broken bones which somehow had to be immobilized. Splints were the first form of protection. The Egyptians in 1600 B.C. advanced beyond the primitive wooden splints and wrapped the limb in bandages of cloth, stiffened with gums or waxes. A thousand years later, Hippocrates recorded the use of bandages smeared with wax and resin. In ancient days in India, the natives used clay to make a mould for fractured limbs.

An Arabian physician, Rhazes, in the 10th Century A.D., used bandages spread with lime and egg white. Not only was the support firmer, but it had a better appearance. Egg white was used for stiffening as late as 1834. Other materials were mixed with the egg white from time to time, such as oil, vinegar, straw, etc. The chief defect of these splints was that they were not readily removable. The limb usually became very wasted and any abrasions progressed to ulcers or infections.

A British consul in Bocra reported in 1798 that plaster of paris (gypsum) was being used to encase fractured limbs. He noted the obvious advantage of this substance—that it could take the form of the limb and was thus less clumsy. Its hardness was also observed. In 1816, ground up blotting paper was added to the plaster in France. Twelve years later, physicians in Berlin devised a method of putting the limb into a wooden box and pouring liquid plaster of paris over it until the limb was almost covered. The box was removed after the plaster was set. This crude "window" allowed the fracture area to be observed and did not interfere with the immobility of the part.

Miss Down prepared this material while engaged in post-graduate study in operating-room technique.

The trend next was toward the development of lighter splints with more regard for the preservation of muscle tone and treatment of wounds when they were present. Dr. Mathysen, a Dutch Army medical officer, described the first plaster of paris bandages in 1852. Finely powdered plaster was rubbed into strips of coarse-meshed cotton by hand. These were rolled into bandages. During the Crimean War they were used by both armies though civilian doctors continued to use the starched splint method.

Seventy-five years ago, a plaster of paris jacket was devised for treating Pott's disease. Other substances in use at this time included: gutta-percha, wood, leather, starch, and bandages stiffened with gum, glue, paraffin, and sodium silicate. The latter was painted on to cotton material in layers. It was very slow in drying but it continued to be used as recently as 1914. However, by the turn of this century, plaster of paris was accepted as the best material for casts.

What exactly is plaster of paris? It is the name given to powdered, dehydrated gypsum, the same substance that is being used so extensively today as a form of insulating material in our homes. In the modern preparation of plaster of paris, the gypsum rock is first ground to a powder. This dust is heated in large kettles equipped with agitators. The heat is accurately controlled to avoid too great or too little loss of the water of crystallization. The temperature reaches between 300° and 400° F. The powder is then sifted or screened to remove all lumps and at this time the desired accelerant or a retarding agent may be added. Sodium chloride or gypsum crystals speed up the rate at which the plaster will set. Such substances as animal hair, horny organic material, gelatin, or vinegar

may be added to slow down the hardening process by protective colloidal action.

Certain reactions take place in the media during the setting process. When water is added to pure plaster of paris, gypsum crystals begin to form. During the formation of these crystals, the potential full strength is determined on the basis of the closeness with which the crystals interlock. Crystallization takes from twenty-five to forty minutes and, when it is complete, the mass is said to be "set." It has now attained one-third to one-half of its final strength. Full strength is gained with the drying out of all excess water. This excess works its way through the interspaces of the gypsum crystals and evaporates from the surface of the drying mass in from eight to twenty-four hours, depending on the size of the cast.

The requirements of the best orthopedic plaster of paris are that it shall be 99 per cent or more pure gypsum; that it be very finely ground, flour-like in consistency; that it be pure white in color; and that it be thoroughly mixed so that the setting time will be uniform for the whole cast structure. The plaster of paris bandage is made of crinoline, sized with starch, and thoroughly impregnated with the gypsum. It must be stored in a dry place so that moisture will not be absorbed from the air, prematurely causing crystallization.

Modern Treatment of Fractures

First aid in emergency treatment is designed to control the degree of shock as much as possible and to avoid further injury. To this end, the limb is immobilized by the application of a temporary splint, pending treatment by the physician. Securing the limb in a pillow, firm enough to provide support, is a very satisfactory first aid measure. If it is absolutely essential that the patient be moved before the injured limb has been fixed, adequate support should be given above and below the site of the fracture and traction should be made in the line of the long axis of the bone to prevent either rotation or an angular motion.

In most cases, some form of anesthesia, either general or local, is given before the fracture is reduced. If a local is ordered, following the work of Bohler, a solution of novocain (20 cc. of 1 or 2%) is injected into the hematoma of the fracture. The area thus becomes anesthetized and the regional muscles relax, allowing manipulation and reduction.

An example of the use of closed reduction might be found in the manipulation, reduction, and application of a plaster cast for a "Colles fracture." This is a fracture of the distal end of the radius. It is usually due to a fall on the outstretched hand, resulting in a backward displacement of the end of the radius. This fracture can be reduced quite easily and the wrist is maintained in position by a cast. In this, as in all cases where casts are applied, we must watch carefully for consequent swelling and discoloration of the extremity.

Some fractures may require weight traction or it may be used for gradual reduction without resorting to the use of anesthetics. Traction may be secured through the use of moleskin adhesive (humerus), weights and pulley (femur), Kirschner wire traction, etc. Mechanical apparatus when applied to the body requires constant supervision. The points in the nursing care which should receive special observation include:

(a) That the pull is in the line of the normal bone.

(b) That the weights hang free.

(c) That the foot is in balance.

(d) That the foot is supported properly to prevent foot-drop.

(e) That the patient has not slid down in the bed thus destroying the effect of the traction.

(f) That there are no signs of abnormal pressure. Pressure sores may develop in a comparatively short time.

In compound fractures, all traumatized muscle, fascia, and skin edges are excised, blood clots and loose, small fragments of bone removed, and the protruding bone surfaces, which

are contaminated, must be excised. Local anesthetic is not practical for the open reduction of fracture. In some instances it may be necessary to use grafting materials to ensure proper alignment and recovery.

One of the interesting, newer forms of treatment for fracture of the shaft of the femur is the application of the Roger Anderson splint. This utilizes the principle of well-leg traction. Special apparatus is necessary. In this method, skeletal traction is kept constantly applied to the affected limb by means of a Steinmann pin through the distal end of the tibia. At the same time, countertraction is secured by a pulsion force against the well leg. X-rays of the part are taken to locate the fracture site. The pins are then inserted in the desired direction. A bolt is placed on each pin and then a bar joins the two bolts. By tightening the bolts on the pins and bars, (after x-rays show them to be correctly placed), the apparatus is kept in the desired position. Advantages of this form of treatment are: immediate ambulation, painless convalescence, good end-to-end reductions, patients may be more fully clothed, minimum hospitalization. However, the closest watch must be kept for pressure on the well foot.

The Nurse and the Social Revolution

CHARLOTTE WHITTON, M.A., LL.D.

Average reading time — 27 min. 48 sec.

THERE CAN now be little question that the years from 1914 to the present have marked a change and shift in the structure of society, as tremendous in its upheaval and subsidence as those which marked the evolution and decay of feudalism, the growth of the mercantile and commercial society which followed upon it, and the subsequent domination of the forces emerging in the industrial revolution. These years, to which most of our present generation belong, will likely be described as "the era of the collectivist revolution." We have not yet lived through these changes to the end; in fact, in these very months we are "being swept into the centre of a constitutional vortex of which no one at present can see the result: the age-long question, marked by a new intensity, of the relation between government and individual and particularly between the government as employer and those whom it employs."

Mass planning, mass organization are characteristic of the modern industrial and urban economy and it is one of the tragedies of a dwindling democracy that the problems, created in such a society, call for comparable methods to meet them. Men look to the state to become the dominant agency in life. Not the community as a spontaneous and vital entity but the community's organized administration tends to become the responsible thinking, planning, and determining power, assuming, dictating, and discharging more and more of the functions which the individual formerly exercised on his own or in free and co-operative enterprise.

SERVICES MUST BE PAID FOR

One of the editorial staff of *The Economist*, friendly and forward looking in the development of modern social services to reinforce living in this massive modern state, warns, however:

> A country can have only the standard of living it can pay for; and the standard of living includes the National Health Service as one of its components but only one and not one with an overriding priority.
>
> It is often argued that a health service will increase the national income

because it will bring better health to the workers with a consequent increase in their productivity. But the argument is just the same for all the social services. Workers will produce more if they are better educated, if they have more security, more comfortable houses, cheaper food, and the prospect of an adequate pension on retirement. Some of this may be true—in the very long run. In the short run, there is no escaping the fact that the social services have to be paid for, out of taxation, in one form or another.[3]

These relationships should not be left out of any responsible discussion of any welfare provisions, nor should some appraisal of the background in which any specific scheme or service is set.

The Canadian Setting

Our background is Canada, at the mid-century 1949-50. Youngest of the really new states of western civilization in this era of sudden and sweeping change, Canada is, in some respects, fortunate, in others unfortunate, because of that fact. She is fortunate in that the mould of her social structure has not yet been fully and firmly set and, therefore, is flexible enough for adaptation. She is unfortunate in that, thus early in her growth, she is faced with the challenge of adjustments which are shaking older, wealthier states to their very foundations.

The Canada of 1900 and the Canada of 1950 contrast sharply even in their physical setting. Of course, with the adhesion of Newfoundland, we extend to the very rim of the Northeast or the Northwest Atlantic (it depends on your point of view). The distribution of population, and so of development and influence within the country itself, has significantly altered. In 1900, the median of population was about Ottawa, for only 350,000 people—about 7 per cent of the population—then dwelt west of Ontario. Now a third of our people dwell there and the central line of Canada's settlement runs near Sault Ste. Marie.

Canada was predominantly rural: 6 out of 10 people lived in the country districts. There were only two cities — Montreal and Toronto — over 100,000 in population. Manufacturing, trade, and finance were concentrated in a few eastern centres and our production turned on a few staple lines. The development of hydro-electric power was beginning, but the railways, even the C.P.R.'s western lines not yet of age, were supreme in transport. A few automobiles moved in short, slow, dangerous range along roadways built for heavy horse-drawn drays and were rarely risked by "the carriage trade." This was typical of the whole tempo of life.

Now, only 45 per cent of Canadians are left dwelling in rural areas and not all of them are in agriculture. It engages but 30 per cent of our people today. Only 3 per cent are in forestry and fishing, about 2 per cent in mining. Manufacturing takes almost a quarter of them (23 per cent) and trade and finance, 13 per cent. Personal service—that is, hotel management, restaurants, catering, etc.—holds about 8 or 9 per cent; the professions, 6 to 7 per cent; transportation and communication: telegraph, radio, and water, road, rail, and air transport, about 2 per cent; construction, 5 per cent, and the public service, at dominion, provincial, and municipal levels, 4 per cent.

The setting of Canadian living has also shifted—practically one out of every four Canadians now lives in one of the nine cities over 100,000 in population and another 15 per cent in those between 10,000 and 40,000. We have now essentially the same number of people living in our towns and cities over 5,000 as in all our rural areas, and this population is spread over an area vaster than the United States or the continent of Europe.

Consequently, we must work out ways and institutions of living to serve populations and living conditions as industrial, urban, and complex as those of the teeming cities of these continents and, at one and the same time, provide for life and economies as primitive as their poorest

frontier areas. We must do all this with a population less than that of New York State or the metropolitan London area. Surely, never in social history, was a problem so complex, posed to so few people of such diverse strains and occupations in a territory so vast and with resources so great but presently so slight and difficult of development as Canada's.

The British Warning

British experience of recent months, in the health and social services, seems to establish one warning beyond dispute, and one that is applicable whether the economy be capitalist, collectivist, or communist. It is that we must know well and perceive clearly certain specific relationships—the assessment of the resources, no less than the needs, of the community we would serve; and of its capacity, in both income and man- and woman-power no less than technical facilities, to sustain the program and mechanisms, designed for the greater well-being of a greater number of its people.

The nature and extent of the problem of health care for any given unit of people must be seen against this broader background of the particular community—be it nation or city, town or rural area—its resources and the nature and activities of its people, and the whole intricate question of all its human needs, welfare, and education, no less than health.

Within the specific health sector again there must be this integrated approach with awareness always of all elements therein—the community, the over-all community services, the clerical and teaching centres, the hospitals and the healing professions and personnel.

Health Service Not Insurance

It is of major importance to emphasize that health insurance concerns the nurse little if at all. To quote the official British publication, *The National Health Service:*

> The health service is quite separate from the insurance scheme, which exists to give people not medical care but money during sickness and unemployment, and to provide pensions.[2]

It is a state health service, covering the entire population, into which the United Kingdom and Scotland have been, even its proponents must admit, too precipitately plunged. But it is health service, not health insurance. The insurance deductions of employer and wage-earner, under the old health insurance plan, provide one dollar out of every nine; the other eight dollars come from taxes of the central and municipal government.

Even if Canada hesitates to risk a state health service, health service as a public utility is already far on its way through the numerous prepayment plans of government and private employers and through the personal underwriting by tens of thousands of their hospital and medical care. The integration of all these schemes and of the resources to meet them, and of their extension to include due provision for nursing, dental, ophthalmic, and pharmaceutical needs, is coming as surely as day follows night. The costs and mechanisms may be adjusted as between public and private enterprise and responsibilities, but pooled health service is taking firmer shape and larger form daily.

The present Canadian health service planning is sound in that we are making haste slowly by careful survey and study, through the provinces, of the proper agencies of administration. A representative British medical leader writes:

> The scheme embodied in the Act is, on the whole, a good one and was desired by a majority of the public; but to launch so comprehensive a scheme in such haste was asking for trouble . . . The basic defect lies in the fact that too many people require the services of too few people.[3]

We may avoid this situation if we advance slowly by evolution, not revolution.

The Range of Health Services

It is 560 years since the first health measures were passed in England—a statute of Richard II, enacted in 1388, prohibiting the pollution of

rivers, ditches, and open spaces. It is just 100 years since the first use of the term "public health" appeared in a British statute in the Act of that name, introduced by Lord Morpeth in 1848.

Provision for the health of all the people still begins on this wide periphery of positive approach in education and protection. The defences reach far out—the sites of communities, their drainage, water supply and sewage disposal; their housing provisions; their safeguards and controls over the factories, shops, and offices where people work; the centres in which they gather for food, recreation, worship. Consequently, in this first trench, broad and effective liaison must exist between the central and the municipal authorities, and among the officials and services, planning and administering public works, and supervising building permits, the architectural and construction personnel in the community, both public and private; the authorities licensing and inspecting market, business, commercial, and industrial facilities, and supervising play and recreation centres and public gathering places. The operating personnel will be drawn from ranks of the engineering profession and from the medical profession but before and beside both, as educator of the public, as visitor and as inspector, will be found—the public health nurse.

Our enlarging knowledge of what contributes to good health, and what constitutes hazards to it, dictates the second line of defence, also well out in the community—in industrial and occupational health services, in the prevention and control of communicable disease, and in the positive care and education of the infant, pre- and school age child and student. Here the responsibility is of a threefold nature —preventive service, again; health education, public and personal, and actual treatment, both of a protective nature, as in vaccination and immunization; and curative in the correction of such conditions as malnourishment, remedial defect, etc. Here the function of education, health examination and supervision, and medical care meet; here industry, business and labor personnel, the educational and health authorities and, of course, the parent in the home, all meet. But, again, a constant factor in all areas of activity and service is the public health nurse.

Closely related comes yet a third line of inner defences, fighting when disease, sickness, ill health, or injury have already breached the wall—the clinics of health centre or hospital and the nursing service in the home of the person under care. The stronger and more skilled the personnel, the more adequate these resources, the less the cost in disruption of occupation, earnings, and home life, and in readjustment for the individual in his setting; the greater the volume of treatment and care in that setting, the smaller the recourse to the more costly care of hospital, sanatoria, or other custodial unit.

Here, the extending resources of medical science come into play in assurance of diagnostic, radiological, and pathological service, available to practitioner, hospital, and patient alike. Here the efficacy of personal instruction of the patient, the practicality or risk of treatment by his or her family, at home, turn upon the availability and efficiency of capable clinical and home visiting nursing staff. And here, more probably than in any other one focus in any plan of health care for the people for the relation and reconciliation of the personal interests of the patient, the private practitioner and the personnel of the public service are affected. Here is that vital link, with the setting behind the patient and its relationship to his mental and spiritual, no less than to his physical well-being, strengthened or broken.

The holding of the last outer trench, as it were, of treatment of the potential or the convalescent patient, in his natural setting, turns in large part upon the linking in of bedside nursing service, preferably on an hourly and community bureau basis. But it turns, also, on integration with

two other auxiliary resources—the *nursing subaltern*, who can be used for much of the home nursing and minor nursing routines from which the fully qualified nurse could be freed to the greater use of her greater skills; and the *domestic aide*, to whom the household responsibilities can be allocated to permit the ordinary life of the patient's home to carry on with the least possible disruption, whether she be there or under custodial care which would be hampered in effectiveness by worry or concern over the home situation. The easing of that anxiety may involve economic aid or welfare service in the home. It may mean assurance of care there or elsewhere for dependents. It may mean all or any of those racking worries that, added to the worry of the illness itself, easily overwhelm patient or family or both. Here there must be the most concentrated liaison among the personal physician and the clinical centre, the community's full resources in welfare and auxiliary services, and, of course, the patient and his family. And, at its centre, is the nursing service, on duty in the clinic and in the home and again the least common —and so often how "least"—denominator of them all.

When the need cannot be held at this last outer defence and the patient enters custodial care of hospital, sanatorium, mental institution, or unit for the care of the chronic or convalescent sufferer, the custodial responsibility breaks into three areas —general business administration and management, including the operation of the unit, in a sense as a hotel providing shelter and food; medical treatment; and nursing care. Not the least of these and the very core of any good hospitalization is good nursing.

The Place of Nursing

The costliest elements in the health defences are presently two—medical care and hospitalization. They, along, of course, with dental, ophthalmic, and pharmaceutical services, can be the making or breaking of any health service, maintained from and accessible to the entire community. The extent to which they can both be conserved depends, more than on any other single factor, on the assurance of a sufficient supply of adequately trained nursing personnel. That supply is neither now nor potentially adequate, nor are the training resources and procedures, now available in either nursing, welfare, or auxiliary services, fully geared to the changed and varied demands that will be exacted from this nursing and auxiliary personnel in the rapidly extending services under the Dominion Health Service plan. This, in turn, is affording the substructure for the extension of health services to the Canadian people, on a public utility basis, comparable to the educational services. Its maturing can be retarded by years, its costs made practical or impossible as this problem of the amalgam of the whole—the nursing and auxiliary personnel—is imaginatively dealt with or neglected.

The place and responsibility which nursing thus assumes even in the present, but, more so, in the presently emerging health services of the people, throw upon the profession the problem of assuring as wide a variety of specialists, consultants, administrators, and general practitioners as ever confused the senior profession.

The most broadly dispersed, the most intimately delicate in the difficulty of adjustment will be the age-old function of the actual nursing of the sick, whether in domiciliary or custodial care. The setting may change and private nursing, in the sense of the individual nurse working on her own personal retainer, will probably shrink, as has private medical practice already in Britain, to not more than 5 or at most 10 per cent of the whole. Personal, private duty nursing will continue, concentrated on the really ill, whether the nurse works on a daily or hourly basis, on her own, or as personnel of the bedside nursing unit—voluntary or statutory or a blend of both.

Personal nursing will continue to demand heavy personnel on a full-

time basis, in clinical and public health services, but will alternate, to greater degree, with patient and community service, both in domiciliary and custodial care. This will call for a "blend" in nursing personnel, capable both of nursing and of instructing children and adults in positive health, of moving in and out of the occupational clinics and services, dispersed (to save time in transport and absence from work for both patient and health personnel) through both rural and industrial areas. The educational authorities, from kindergarten to university, will want the public health instructor nurse.

Because of the practical problems of population, distance, and finance, certainly in Canada, somewhere along the line, at this level of actual service in the patients' own setting, liaison personnel will have to be evolved in which a "hybrid" may have to be considered. What seems outlined is a nurse who will be in part a welfare worker and a welfare worker who will have some elementary first aid and public health knowledge. Both of these people will be sufficiently aware of the intricacies of each other's fields to act as registrars to refer the problems of major import to the respective agency of major practice.

Both within these ranks of what might be called the "mobile nurse" and in custodial units, there will be an even more insistent demand than now for the nurse with administrative and executive ability for staffing the general mechanism of the nursing resources of over-all health services, and for the specific supervision of technical and personal nursing service within clinical, domiciliary, and custodial units. These "executive" or "administrative" nurses will be required at the very highest levels of the governing bodies and authorities, no less than in the actual operating units of the health services. At the very cog of the mechanism will be the personnel assuring the preparation and the continuous "refresher" instruction of those who staff such vital and varied services. The processes of nurse training and education are already faced with almost paralyzing problems in assuring personnel, adequate in preparation and numbers, for these different types of nursing service and, most difficult of all, of personnel, interchangeable among them or sufficiently "multilateral," to combine, as will be necessary in so many areas in Canada, more than one of these responsibilities and services.

The Supply

The "nursing gap" seems to be showing less promise of closing than the dollar gap and is concerning the same nations. The United Kingdom needs 125,000 nurses and is 45,000 short; the United States, with 318,000 nurses, still has 33,000 hospital beds closed due to the shortage. In 1948 it imported 779 nurses from Canada, a number equivalent to nearly 20 per cent of the total number of graduates of that year.

In general hospitalization in Canada, in the last eight years for which statistics are available, the number of patients increased by 70 per cent, the enrolment of student nurses by only 45 per cent. A study made by the Mental Health Division of the Department of National Health and Welfare indicated an increase of 50 per cent in the number of patients in mental, tuberculosis, and chronic care units in the same period in which the number of registered nurses therein decreased by 200, the non-registered by 400. The National Health Survey of 1943 revealed, in spite of a 28 per cent increase in nurses in four years, a shortage of 4,400, excluding private duty and industrial work. By 1946, the Canadian Nurses' Association studies revealed an overall shortage of 8,700—7,000 hospital nurses, 1,200 private duty, 500 public health nurses.

Ontario is the best served in nurses of all the provinces, yet, excluding public health, private duty, and industrial nursing, the last reports indicated a shortage of over 1,000 graduate nurses and over 400 other nursing personnel.

The Canadian Public Health Asso-

ciation reported to the Dominion Council of Health in 1946:

> The greatest deterrent to the expansion of public health services in Canada at the present time is the lack of trained public health nurses. Existing public health agencies are expanding and new ones are being planned all across Canada, but in most cases these programs are being retarded drastically because authorities are unable to find public health nursing personnel.[1]

Canada's nursing force, at the present time, is about 31,000 active nurses on the registers (with another 7,200 still registered but not active). There are approximately 13,000 student nurses in the hospitals and 10,000 auxiliary nursing personnel. With the target of one nurse for 280 of the population, Canada would need 15,000 more nurses in the next 10 years.

The hospital beds already contracted for, under the Dominion Health Plan, number 15,028, which, when they are finished, will demand 2,700 more graduate nurses and 1,700 auxiliary personnel.

The highest number of nurses on record graduated in 1948—3,991. The net "loss" a year in the profession through marriage, transfers to other work (to which one in 14 nurses go), etc., runs about 2,500, so a graduating total of nearly 4,000 represents a relatively small net gain. Consequently, the situation shows a definite worsening in supply and, at the present rate of graduation and replacement, a continuing problem and a persisting shortage which, even by 1960, will still approximate 7,000.

Training

The problem is, in part, one of *training*, of arduous work, of long hours, comparatively poor remuneration and uncertainty of employment. This is being vigorously explored in the improvement of existing schools of nursing, and in the significant experiment in Canada on the organization of nursing education, apart from hospital administration and on a par with medical, dental, legal, and teaching training.

The problem is perhaps equally one of *supply*. What is becoming increasingly and disturbingly evident is that there are simply not enough girls and young women in Canada "to go round" in all the tasks which the highly organized industrial and urban economy is asking of them.

There is a disturbing shortage of teachers, of whom over 70 per cent are women. To meet arrears and effective demands, about 7,500 a year are now required. Social workers are in short supply; so are first-rate secretarial, stenographic, and clerical workers, and women for executive and managerial posts in all pursuits.

There are only about 250,000 girls, over 16 years of age, going through school in any one year. All recruits for all the work which women do in this nation must come from that pool. If we are going to retain anything like our present social balances, we have to keep 150,000 to 175,000 for marriage, another 20,000 to help in their own farm homes, some 25,000 to assure carrying on household service in hotels, restaurants, catering establishments, etc., even if they flee the private home. The factories want at least 15,000 new young workers continuously, the offices a similar number; governments, at all levels, seek about 10,000 new girl workers a year; trade and commerce would like the same number; other miscellaneous activities, 7,000 or 8,000, teaching 7,500 and nursing not less than 1,500 net increase, which means about 5,000 new entries a year. Add it up and it's insoluble; there just aren't enough women coming on.

If we take the small number proceeding to matriculation grades—47,000 to 48,000—and try to assign them to the pursuits, desiring this admission standard, the problem is even more disconcerting.

Re-organization of Nursing Practice

So, quite apart from the content of training, does this problem of potential supply, along with the indication of the many and varied duties of the nursing personnel in the health

services of a changed social structure, not raise yet another question? Perhaps the solution may lie in larger part in yet another line of exploration already under experiment.

Already 12 schools, in all the provinces but Nova Scotia, are training nursing aides to provide auxiliary personnel, though with a registration of only about 1,000. This represents an effort to free nursing of what is not nursing.

Has enough attention been given to the "job analysis" of nursing—present and future?

Is a re-allocation possible of some of the duties, traditionally assumed by the "all-round" nurse in hospital, clinic, and home? Do the executive functions, opening in the health centres especially, not mean an increase in responsibility and status of some of the categories of nursing?

On the other hand, do the integrated services about the patient in the home, and the extent of clinic and centre work visualized, not suggest the creation of more auxiliary personnel of *nursing subalterns* to take over clerical, laboratory, routine, and comparable duties in clinic and hospital, and of yet another corps to act as *domestic aides*, releasing the trained nurse for nursing?

The Challenge

In the present and prospective functions which the public asks nursing to assume in a changing society there is a challenge of broad and difficult implication. *If the profession fails to meet and master it, solution will come from others, for neither the mood nor patience of the present times brooks much loitering.*

What a philosophical country physician in Britain recently said of his profession applies, comparably, to the closely allied one of nursing:

> A profession to whom clinical freedom is its life blood, and which knows better than any the strange particularity of every individual, has suddenly been brought under the control of a single Minister and face to face with an ideology that seeks to attain that all should be treated alike.[3]

A Working Party

Is it not urgent for the leaders of Canadian nursing to depart from their traditional secondary position of observing and reporting, leaving the diagnosis to their elders, the physicians, and to take the initiative themselves? That initiative might focus on a quite possible objective. It would be nothing less than the organization of a "Working Party," chaired by one of nursing's own ablest members but drawn also, on nursing's own selection, from representatives of the public, who want nursing, and from the allied groups with whom the nurse's work is primarily done—the medical profession and the governing bodies in hospital and municipal administration.

For that Working Party, I suggest that nursing seek official recognition but quite independent financing and, to it, I further suggest that the nursing group grant the broadest possible scope of inquiry and discretion with the overall instruction to report in the interests not only of the nursing profession and its specific place and powers in the responsibilities of this rapidly changing structure of the care of the people's health, but also in the relationship of nursing care to the general setting and, what the nurse has so long and faithfully perceived and practised, to the greatest well-being of the patient.

And nursing will find, as a profession, as nurses long have personally, that the public will give the nurse and nursing its confidence, its cooperation, and its gratitude.

One of the wisest of England's town practitioners recently wrote:

> Every school boy knows that Canute demonstrated that you cannot stop the tide. Much as many of us dislike the idea, we must realize that the tide of human thought is now in full flood towards collectivism. We cannot arrest that tide, but we can try to direct it into channels that will allow time for the harnessing of its energy to the betterment and not, as it is threatening at the moment, to the destruction of all those higher attributes which in the past have contributed so much towards the welfare of humanity.

. . . The present is the workshop in which the future is being made.[3]

Yours it is, from your knowledge and experience, to attempt to direct and harness these new currents while there is yet time, for—

The Moving Finger writes; and, having writ,
Moves on: nor all your Piety nor Wit
Shall lure it back to cancel half a Line,
Nor all your Tears wash out a Word of it.

REFERENCES

1. C.P.H.A., 1946. p. 3. Appendix C.
2. *National Health Service*, p. 5. H.M.S. Office, 1949.
3. *Practitioner*, Sept. 1949. p. 36. *Ibid.*, p. 37, p. 102.

Magic and Medicine

L. BLAKE DUFF

Average reading time — 4 min. 24 sec.

IF WE COULD take the very earliest view it is in a cave in the Pyrenees, a picture there on the rock wall, drawn by an artist of 15,000 years ago —portrait of a doctor. This medico, dressed in animal skins, had his own skin painted and he wore antlers for head-gear. His skills, one may well guess, lay in his ability to scare off or destroy the evil beings who lurked in sun and moon, in the clouds and skies, and in the winds and rain, in the streams and trees, and in other people. Disease was magical; the cure, too, had to be magical. When science began its war against incantation and charm, magic and superstition, is not known but we do know the fight is on yet. Gradually and painfully to this date science has won its way. It still has miles to go.

In 1878 the German, Georg Ebers, found in Thebes the oldest complete book known to man. Because of its unique position in the chronology of books it is famous among bookmen. But it is famous on another score for it is a compendium of all the medical knowledge of Egypt 35 centuries ago. While it is a medical book it is very wide and generous in its scope—telling what to do about mice and lice, falling arches and bald heads. You will find old friends there, like pyorrhea, tumors, and fevers; old remedies like mustard, castor oil, and hartshorn. *For baldness:* rub the head with a mixture made up of fats from the hippopotamus, lion, crocodile, and the goose. (Something very appropriate about the goose being in there!) *For an infected eye:* Take half a human brain, mix it with honey, and anoint the eye.

Disease was here on this earth waiting for the arrival of man. To confront it man had only such silly and futile weapons that he was helpless in trying to meet the challenge of his greatest enemy. This continued to be so for long centuries after the Ebers papyrus. The Black Death of 600 years ago was the greatest catastrophe the human race ever endured. It reached every corner of the known world. Nearly half the population perished in swift and horribly painful death. The Black Death destroyed a larger proportion of the population of every European city than the atom bomb killed at Hiroshima.

Plagues followed plagues, cities were devastated again and again, as London in 1665, Philadelphia at the break of the last century, and our own cities in eastern Canada in 1834.

The march of time had to come right down to our own era before it was realized that these scourges came not from a malignant god, but from ignorance. It took all the countless ages to learn that disease came with dirt and filth, that it was spread by uncleanness, by the fly, the flea and the mosquito, the mouse and the rat; that the best passport to good health was clean water, clean

milk, and clean food. It is not so many years ago that every hotel washroom in Ontario had a roller towel and a chain comb. Now not one could be found! Where is the common drinking cup? Its era seems as far away as that of Nineveh and Tyre yet the man who inaugurated the campaign to abolish the common drinking cup from the face of the earth is still living.

We talk so much about the good old days. There never were any. These are the best days ever. Dr. J. J. Talman, a few years ago, by means of church registers, newspapers, and gravestones made a study of deaths in the 1820's in the Niagara Peninsula. He found that the average age at death of all the persons listed was 25 years. Rural Ireland, twenty years later, had an average of 19. Four hundred years ago the average life expectancy was 8 years; now it is crowding 70 years.

Medical science can well say of itself, "I am the strongest force operating in modern civilization toward human betterment." That is a tremendous thing to say, but it is true.

The first man licensed to practise medicine in Ontario was John Gilchrist. He walked 70 miles from Cobourg to Toronto to be examined by the Medical Board. That was in 1819. But we had doctors before that, wherever they came from and whatever equipment they had for practice. John Strachan (later Bishop), writing in the *Kingston Gazette* in 1814, said of doctors:

> They comprehend not the causes or nature of diseases; are totally ignorant of anatomy, chemistry, and botany. These are men who have never been regularly taught. They are, indeed, so unschooled as to be unable to read the books on medicine and surgery.

It may seem a bit odd that the great place in literature is held not by the preacher, the teacher, or the lawyer, but by the doctor. The father of all French writing was François Rabelais, whereas in English we go back to St. Thomas Browne with his "Hydriotaphia" and "Gardens of Cyrus" and Robert Burton with his monumental "Anatomy of Melancholy." These are works that belong in the great stream of English literature that began with Chaucer of "The Traveller" and Goldsmith, of "The Deserted Village." Tobias Smollett of "Humphrey Clinker" and "Peregrine Pickle" were forerunners of Keats and Shelley who walked the hospitals of London. In our own time among these doctor-writers we have Anton Chekov, Axel Munthe, and Conan Doyle. One of the greatest was, of course, Sir William Osler, great in his profession, great as a bookman—a curator of the Bodleian library, a delegate to the Oxford University Press, and president of the Bibliographical Society. Nor could I close on a better note than a quotation from Osler:

For yesterday is but a dream
And tomorrow is only a vision;
But today well-lived makes
Every yesterday a dream of happiness
And every tomorrow a vision of hope.

National Health Week

Dr. E. A. Hardy, secretary of the National Health Week Committee of the Health League of Canada, has issued an appeal to national, provincial, and local organizations to co-operate during Canada's forthcoming 6th annual National Health Week, scheduled for *January 29 to February 4.*

"National Health Week is sponsored by the Health League in official co-operation with Departments of Health and Departments of Education," said Dr. Hardy, "but its success will be made possible only through the support of the nation's numerous public-spirited organizations, such as service clubs, women's groups, and other professional and voluntary societies." We hope that nurses will give their full support to this worthwhile project.

R.C.N. Civilian Health Department

NORAH K. CORNWALL

Average reading time — 10 min. 24 sec.

YOU AND I, standing on the shore of some great body of water and looking at a graceful ship gliding along, destined perhaps for some far-away land, seldom think of the hundreds of pairs of human hands that have worked night and day creating, assembling, and testing the many parts, until finally, after long months and sometimes years, she slips down into the water for her official launching and trial run. This is only the beginning of a ship's life. There is the tremendous task of keeping her in shipshape. It is in our dockyards where this is done.

In the naval dockyard at Esquimalt, B.C., ships of the Royal Canadian Navy, as well as other ships of many nations, find a sanctuary for rest and recuperation following their sometimes turbulent trips across the mighty Pacific. Employed here are hundreds of people, both men and women, in many and varied occupations. There are university graduates and tradesmen—stenographers, messengers, postal officials, clerks, highly skilled technicians, electricians, storemen, executives, gardeners, mechanics, canteen attendants, cooks, signal specialists, draftsmen, carpenters, plumbers, janitors, chauffeurs, engineers, and many others. It is like a small city, only four miles from Victoria. About a mile away by land and half a mile by water is the Naval Barracks, where the actual training of our present and future naval personnel takes place.

In the spring of 1944, I was asked to open a new department in the naval dockyard—a health department to service some thirty-two hundred civilians employed in two of our West Coast naval establishments. There is always something tremendously exhilarating about pioneering, whatever field of endeavor it may be in. And so, with six years of varied experience in several fields of nursing behind me, I launched forth upon what seemed at first to be an almost hopeless task. I wondered many times whether we were going to be able to succeed against the tide of traditions which had to be broken down, volumes of outdated rules and regulations to be dealt with. Heretofore I had always nursed in surroundings which had been ready made. Now there was a three-roomed, very old, red brick building which I was told might be used "providing a naval department did not want it." To the average navy man, a civilian employed in a naval establishment was someone to be tolerated but that is all. It made no difference that many of these same civilians were retired navy men —some with distinguished service records, some with twenty years of service behind them.

The formative period was spent in assembling medical and surgical requisites as well as furnishings and other necessities. Ordering anything in a government establishment is not like buying from a store. For every article desired, from a pen-nib to an operating-table, one must make seven copies of the requisition and have it authorized by two and sometimes three signatures. It must then be registered, stamped, and finally submitted to the department where you hope you may find it. If you are lucky, you receive said article, in whole or in part, in anywhere from two weeks to two months. Occasionally the article in question is not approved, or is not in stock, in which case it has to be ordered from an outside source. Sometimes NSHQ, Ottawa, must be approached before approval or disapproval is granted. As the health department was a new departure, almost everything one was used to working with seemed to be unauthorized. This has been amended since, after five years of existence, we now are an established department.

Then there was the question of furnishings. Fortunately, Providence came to my rescue in the form of a dear old gentleman who had served under five sovereigns and was still serving as best he could. He knew all about everything, it seemed. Between us we unearthed some furniture from a store-room which had originally been used on ships which had been converted into warships. I found someone else who had been an upholsterer and, with the help of the carpenters, painters, plumbers, electricians, and a gem of a janitor, we finally were able to open the doors of a rather strange health department. It was then June, 1944.

Not knowing exactly what type of patient would pass through our doors, one had to prepare for almost every type of emergency. Having no doctor to call upon for assistance, the initial stock of medical and surgical requisites had to be only those which a graduate nurse was authorized to use, without the aid of prescriptions and doctors' orders. Little by little the clinic grew to meet the needs as they presented themselves. It was a wonderful experience. Many times I have blessed my very strict supervisors for their rigid and thorough training.

During the war, when the refitting of ships had to be done at top speed, we experienced many severe accidents. Now the pace is slower, our safety department is very active, and the prevention side of the ledger is more heavily balanced than formerly. We have tried to make our personnel health and accident-prevention conscious through organized classes in first aid, and by safety supervision and follow-up work.

In 1944, our staff consisted of one registered nurse and a janitor. In 1945, a small unit was opened to service men employed in our Naval Armament Depot, boiler and machine shops. A first aid attendant was installed here. He was an ex-naval sick bay attendant, a registered pharmacist, and a St. John Ambulance industrial certificate holder—a most valuable person. A year later, another unit was opened at Kamloops, B.C., where a R.C.N. Ammunition Depot is located. A graduate nurse with excellent clinical experience was employed here. The following year a similar department was opened at *H.M.C.S. Naden*, our naval barracks where a fair number of civilians were also employed. A graduate nurse was engaged to administer this. Six months later another ex-naval nursing sister was engaged to set up and operate a similar department at *H.M.C.S. Royal Roads*, then a college for naval cadets, now a combined services college.

Our duties have gradually become standardized, as well as our equipment. Our patients are our friends. We are all Dominion Government employees working in his or her particular branch. I think that is one reason why it is all so enjoyable. Our duties include:

(a) Maintenance of equipment and supplies; (b) ordering and replenishment of same; (c) first aid to all accidents and illnesses, both major and minor; (d) proper reference to outside doctors, of patient's own choice, where indicated; (e) making out and submitting compensation forms and accident and illness weekly and monthly summary sheets; (f) keeping of personal record cards in a filing system; (g) treatments given include: dressings, aural syringes, eye baths, removal of foreign bodies, massage, foments, poultices, medications (within nurses' jurisdiction) for rhinitis, headaches, and other disorders; (h) co-operation with outside doctors in administration of prescribed drugs, serums; removal of sutures, dressings, etc.; (i) social service advice to employees for families, with referral to proper civic and provincial agencies, consent having been obtained beforehand from employee; (j) public health of canteens which are periodically examined; (k) pre-employment and biannual physical examination arranged for all food-handlers, including chest x-ray and Kahn test; (l) arrangements made by telephone for (*1*) transportation of severely injured to local hospitals or doctors' offices, (*2*) dental appointments, (*3*) medical appointments; (m) welfare extended to tempo-

rary indispositions, thus minimizing lost time; (n) making and referring for sterilization dressings and other surgical requisites.

In 1946, a Royal Canadian Naval Well-Baby Clinic was established on the West Coast. As no other building was available at the time, our space was used for this, with clinics twice a week. The nursing sister who established this was a graduate of the Hospital for Sick Children, Toronto. We had a wonderful year together, doing the type of work we both loved. Soon, however, the baby clinic became too large and required its own quarters. It is now considered the largest well-baby clinic on the West Coast.

For grave emergencies the services of the R.C.N. medical officers are available. The Motor Transport Department is prepared at all times to transport seriously ill and injured persons to the city hospitals. This transport service is also given in minor conditions which might be aggravated by a public conveyance. Ambulances and cars are both at our disposal, if necessary.

In the five years since our beginning we have also assisted the provincial tuberculosis unit in conducting its chest x-ray surveys when their van visits naval establishments. Almost all our employees have taken advantage of this service.

A blood donor service was established to assist our employees and members of their immediate families when transfusions were indicated. For this a voluntary blood grouping survey was conducted with a most gratifying response. Volunteers were transported to and from the local hospitals without loss of pay. Since the establishment of the Red Cross blood banks this is no longer in operation.

Occasionally our patients come to us with problems which they have been harboring for years, which they have been perhaps afraid to report to a doctor. Sometimes we are able to detect symptoms which are indicative of future serious troubles and can explain to them how very important it is to have these things attended to in order to ensure them of a longer, healthier, and happier life. It is wonderful how they respond to advice and permit us to make the necessary appointments. Sometimes operative procedures have been necessary.

Family problems are often much easier to shoulder by talking them over with someone who can help. Perhaps a mother of a family becomes ill and must go to hospital. By arranging an interview with the Red Cross Home Service, someone suitable will be engaged to live in the home and keep everything running smoothly until the mother's period of hospitalization and convalescence is over. In this way no schooling is missed; father is able to continue in his daily work; bills can be met and no further burdens are added.

What the future of our department will be we do not know. We are all aware that "once an organization rests on its laurels it is finished." There is much to be done. There are plans for a much broader health scheme which as yet we have not been able to put into effect. Our proposed program would necessitate the services of a doctor who could conduct, with our assistance, a preventive and corrective health plan for all, including compulsory physical examinations for every employee and prospective employee.

This is our story. From my little building, over which a Red Cross flag flies, one can see many of the ships of the Royal Canadian Navy which are based on the West Coast. Destroyers, cruisers, frigates, minesweepers, mine-layers, corvettes, and small harborcraft—all are tied up alongside one of the many jetties. Each in turn may leave and not return for several days, weeks, or months. Where they go and what they do is a naval operation, just as important in peacetime as it is in time of war. These are the ships we are servicing. In turn we feel we are serving our country and the principles of freedom Canada stands for.

No woman ever found success at the bargain counter.

Institutional Nursing

Color, Line, and Balance

SISTER FRANCES LOYOLA, B.Sc. (H.Ec.)

Average reading time — 8 min. 48 sec.

"O BEAUTY, ever ancient, ever new," cried the fourth-century Saint Augustine to his Creator. Deep in the heart of every human is a longing for beauty, for loveliness—reflections, however faint, of God who is Infinite Beauty. How pathetically this is sometimes evidenced as when we find in a slum district a tin-canned geranium on a narrow window-ledge, cherished and nurtured for the sake of its brave, bright bloom.

The institutional nurse who endeavors to beautify the hospital not only satisfies her own innate cravings but is doing something worthwhile for her patients. Rest is one of the essentials in hospital therapy. Acoustical treatments and other devices aim at promoting this so-necessary rest through quiet; the simplicity of true beauty rests the eye, the mind, and the whole being.

We have gathered here a few fundamental principles that may be helpful to those who are but making acquaintance with the intriguing, if somewhat puzzling, problems of interior decorating—an amateur speaks to other amateurs.

Gone is the era when it was considered necessary to have everything in the hospital glaringly white. But in the application of color only very great artists may trust to intuition. Fortunately, there are guiding principles to aid the rest of us.

The exposure of a room, its purpose, and its size have a bearing on selection of colors. Sunny rooms ask for a background of cool colors; rooms lacking sunlight call for warm colors. Reds, oranges, and yellows are warm colors; rose, ivory, buff, pink, coral, brown are warm tones. Similarly grey, violet, and greens have the same cool feeling as blue. Color scheme examples are:

NORTH ROOM: Color theme, *red*—pink walls, chintz in the whole scale of reds from deepest wine to palest pink, mahogany furniture. Cool touches for relief may be in complementary color, deep green, with white accessories.

SOUTH ROOM: Color theme, *green*—a cool quiet color. Nature mixes green most successfully so we can use varying shades and tints of green with warmer notes to relieve them—honey-toned, blond furniture, gold foil lampshade, and chartreuse accessories, all off-shades of yellow. Draperies may be of striped materials combining green, yellow, and brown.

EAST ROOM: Color theme, *medium yellow*—used in walls, draperies, and blinds, it maintains a feeling of sunlight long after the sun has left. With yellow use a 50-50 color plan—some warm, some cool; red, giving strong warm accents; pale green, definitely cool.

WEST ROOM: Getting strong sunlight in the afternoon will be pleasing in *cool blue* with warmer yellow and brown to complete combination. Neutral grey may tie warm and cool colors together.

To balance colors we are advised to use three major colors, giving the small proportions to the most brilliant color—e.g., 50 per cent grey, 30 per cent yellow, 20 per cent red. Although other colors may be present they should appear only as soft, subtle undertones. "All colors are harmonious if used in the right proportions" is an oft-repeated dictum in decorating classes. What artistry there is in a mixed bouquet of garden flowers!

Sister Loyola hails from Charlottetown, P.E.I.

Good colors are clean and clear; bad colors are muddy and vague. "Avoid drabness in your color scheme," writes Christine Holbrook. "Don't choose lifeless and neutral tones because they show less dirt and are the easy way out in matching pieces and blending accessories. Give your rooms a lift with the loveliness of bright colors." This drabness may be the very thing the hospital designer finds in the woodwork and furniture of the rooms with which she is concerned. She need not be discouraged—she can make her rooms sing with color in fabrics and accessories.

Blessed are you when you come to do redecorating if the colors have been wisely chosen for first wall treatment. Should you have to make radical changes in color of paint, a scratch or marring of any kind will be the more pronounced. If you have to make use of a "handy man" for painting, be sure he understands the correct methods in repainting enamelled surfaces. In your enthusiasm for colors, do not think you can turn a walnut-finished bed into a glamorous magazine-pictured blue with a few strokes of the brush—a cleaning-off job must be done first.

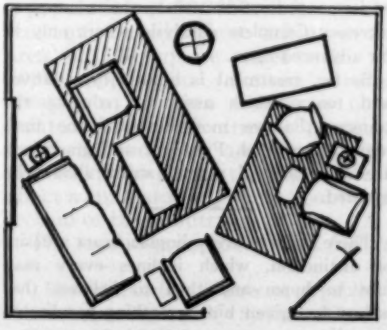
Psychologists declare colors possess definite personalities. Red is vibrant and attracts attention; yellow is cheerful and refreshing; blue is cool and restful. Chemotherapy makes use of these notions, placing hyperactive patients in blue rooms for a quieting influence; treating depressed patients in cheerful rooms of yellow, etc.

The professional decorator has many tricks for making things look other than they are. Can we make use of any of them?

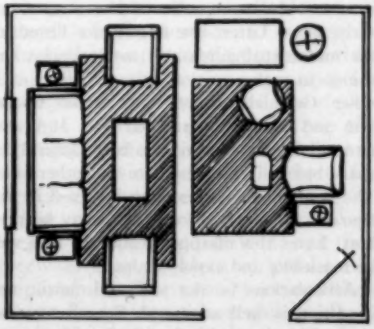
Patients' rooms are always small in comparison to the large pieces of furniture they must house so we gratefully utilize any means of giving a more spacious appearance. Keeping walls and woodwork the same light color is a surprising help. Mirrors help to make a small room seem larger, but the wise nurse will manage so that a very sick-looking patient does not get a chance to view himself (or herself). If the ceiling of room is low, a little of the wall colors should be mixed with the ceiling white to form a closer relationship between walls and ceiling and give a feeling of height. Vertically striped patterns in drapes will give height to windows. Patterns in drapes and upholstery should not be overly large. A landscape or seascape gives a sense of space. If a window is high and narrow, draperies may hang over the wall so that they just cover the wooden window-frame.

Pictures should be kept at eye height; in groups of pictures the bottom of the pictures should be in the same straight line. Framed mottoes or verses are not suitable in rooms for the sick. What a strain on the eyes as the patient tries to read them in spite of himself!

When scatter rugs are used in any room they should be placed in straight lines to achieve restfulness; for the same reason furniture



It looks cluttered!



Attractive and restful

should not be placed at an angle in the corner. Fussy lace or linen chair-back sets are not considered in good taste by professional decorators. These detract from the beauty of a room and say too bluntly, "You are likely to soil the back or arms of this chair." Incandescent lighting is recommended for restful atmosphere rather than fluorescent which is more suitable for centres of activity.

The nurse decorator will be able to express her personality when she plans her own rooms though in the hospital proper she has to think of the patient and the public. In schemes for living rooms more care should be taken to study colors under artificial as well as natural lighting. Thought must be given in placing furniture that correct balance is maintained. Cluttering of too many accessories is a common fault. Why not use a few at a time and change them often? The nurse can fashion her bedroom so that its very vibrancy "makes her want to get up in the morning." Thus the color experts tell us (believe it or not!).

Four-year-old Marjorie Ann called excitedly from the kitchen to her mother in an adjoining room, "Mother, Mother, come quick. The soup is getting bigger than the pot." Color, line, and balance is growing bigger than the dish we have. We shall pull it off now before it boils over but we hope that this unfinished soup will encourage institutional nurses to add to their knowledge of obstetrics, pediatrics, geriatrics, etc., a more intimate acquaintance with esthetics —the science of the beautiful.

Parkinson's Disease

Paralysis Agitans, also known as Parkinson's disease, shaking palsy, shaking paralysis, and trembling palsy, is characterized by stiffness and involuntary tremors of certain muscles in the extremities. It is a chronic disease occurring in later life in men or women, more frequently the former.

The exact cause is unknown. It may occur following acute infections or exposure. Shock, injury, and anxiety are credited as contributing causes. It is not considered hereditary. The palsy is due to the degeneration of motor nerve cells at the base of the brain.

Insomnia, irritability, cramp, and tremor in some of the muscles of the fingers are early signs. Later, the fingers are flexed at the metacarpal joints and work against the thumb in such a way as to rest against each other. Gradually the tremors spread to the arm and leg on the affected side. It is not unusual for the condition to be unilateral for years before it progresses to the other side. The face muscles are seldom involved in the tremors. An anxious expression may be present. Later this disappears and the face will be mask-like and expressionless.

Articulation is not affected until the condition is well advanced. Speech may be slow with a hurried end to some sentences.

The characteristic gait of these patients as the disease advances is known as festination. There is an involuntary increase or hastening of pace until it would appear the patient might fall forward. Should he be stopped and pulled backward, he will continue to back up—retropulsion—giving the impression he will fall in that direction though his body is bent forward. The body tends to bend forward from the hips with the head protruding whenever the patient stands.

Usually, the patient can continue in his occupation for many years after the first symptoms occur. Then, voluntary movements become more feeble and restricted and any excitement or effort causes the tremors to increase. Complete paralysis occurs only in far advanced cases.

So far, treatment is limited to sedatives and tonics which assist in reducing the tremors. Passive movements of the limb may be provided. Fresh air and good food are essential. All mental strain should be avoided.

There lurks in every human heart a desire of distinction, which inclines every man first to hope, and then to believe, that nature has given him something peculiar to himself.

—Samuel Johnson

Public Health Nursing

Problems in the Establishment of a Health Unit

MARGARET MACLACHLAN, B.Sc.N.

Average reading time — 12 min. 6 sec.

THE ESTABLISHMENT of any new service is a challenge with its increased responsibility, creative opportunities, and the many problems, some seemingly insoluble, to be faced. The solution is, at times, clearly seen following an analysis of the situation, while at other times the answer is only arrived at, step by step, through the method of trial and error.

In the establishment of a health unit the many factors, from which the majority of problems arise, would appear to fall into three main groups. *Local factors within the area itself* make up the first group and these are associated with the size of the area concerned; the extent, distribution, and racial extraction of the population; the geographical and topographical characteristics; and the predominating industry or industries engaged in by the population. Problems in this group are individual and peculiar to each area and can be solved only with the local characteristics in mind. A health unit establishing a program in an area of 1,500 square miles with a population of 50,000 will face problems quite unlike those arising in an area of 100 square miles with an 80,000 population. Likewise a rural area in a northern section is confronted with difficulties concerning weather conditions and transportation which do not to the same extent affect a comparable area in a southern section of the country.

The second group comprises *factors within the unit itself*. Problems in this group are usually those of salary, conditions of work, arrangements regarding transportation, etc. With the development of so many official public health programs, policies covering these matters are gradually being established and standards set, with the result that those services which do not keep pace quickly lose personnel. Demand has a way of taking these problems, to an extent, out of local hands. Nevertheless, the senior personnel in any health unit must be ever aware of current trends and be able to convincingly present their needs to those who control the policies—and the money.

The third group of factors may be said to concern *matters which are more general in character, basic in need, and of similar nature regardless of the area served or the type of population encountered*. Therefore, a solution that is effective in one locality has more likelihood of success in another. Problems encountered in this group arise from matters such as—the awareness, by the population concerned, of the service to be established; the insufficient amount of time available to the senior personnel for assessment of the area and the development of basic policies before the program itself begins; the inability to make provision in the budget for capital expenditures, and so on.

The majority of health units at present in operation have faced that overwhelming problem of public unpreparedness for the service they are endeavoring to establish. Is it inevitable that much time and effort

Miss MacLachlan is director of public health nursing with Simcoe (Ont.) County Health Unit.

during the first year or so be spent informing people, individually and collectively, who we are, why we are here, and what we are trying to do—in short—in defending our existence? Are we accepting this as an unavoidable part of that period of organization, or should more thought be given to public awareness of the need for the service, and of the method by which this need may be met, especially in those areas where health units are contemplated? There is no thought here that continuous, informative public education is not part and parcel of every public service. Especially is this true of official agencies since taxpayers have every right to know how their money is being spent. Neglect in sufficiently publicizing a service often results in failure to stimulate interest and so falls short of eliciting the necessary support of the program offered.

Simcoe County is extremely fortunate in that, for the past ten years or so, the rural areas have been offered a program of adult education. Its basic philosophy has been the theory that action in any community stems out of an awareness by its people of particular needs or problems; that this awareness can lead to a study of the means by which these problems may be met and that a plan of action can be developed—i.e., "a program of study and action." Thus, a few years ago, many communities within the county instituted a study of their health needs. They learned what other provinces and counties had in the way of health services—both curative and preventive. They began to realize their own lack of an overall, organized public health program and, most important of all, they began to be vocal about what they wanted done about it. Results came slowly but inevitably. Perhaps the first concrete evidence of action was the establishment by rural school boards of "free" dental services, of "free" vitamin therapy, etc. We still have a job to do in educating people that nothing is really free—somebody has to foot the bill!

When, in 1944, the School Health Service was established in the rural elementary schools, the personnel found community groups—Farm Radio Forums, Federation of Agriculture, and Women's Institute branches—prepared to give intelligent consideration to the program that was being developed. However, it was soon realized by some that the various types of public health services operating in the urban and rural areas were unco-ordinated and insufficient and, therefore, not meeting their needs. Again these groups provided the starting-point from which came the demand for a more comprehensive and co-ordinated public health program. Since the establishment of the health unit on July 1, 1948, members of the health unit personnel, on request, have brought to the people in the communities factual, up-to-date information regarding either the overall picture or some aspect of the work. It is our belief that an informed public creates a more intelligent opinion and thus tends to be more co-operative. We hope, as time goes on, not only to keep the people—the taxpayers—up to date on our work, its aims, accomplishment, and its failures, but also to bring to these groups information along specific lines — mental health, infant and child care, communicable disease, sanitation, etc. Another angle of this method of public education is that we find these groups more willing to let us know what *they* think of the service given, and of needs which are not being met. Thus we hope to offer a more efficient program and one geared to the need as experienced in the communities.

In spite of the preparation made in this field of public education for the establishment of the health unit we have found that the job was by no means complete. Many people, especially at the local level, had little idea of what was taking place. Though aware of the fact that a new program of public health education and supervision was being brought in they appeared to have little idea of what was involved. The history of health unit development has shown that it is

necessary to bring the information to the people directly, as well as through the press. Thus it would seem advantageous that some provision be made whereby this knowledge might be passed on to these people before the actual program gets underway so that they may be in a position to co-operate intelligently and freely.

One suggestion might be that the senior personnel—the medical director and officers of health, the director of nursing and nursing supervisor, and senior sanitarian—be engaged and at work for a period of time prior to the coming of the rest of the staff. The length of this period would vary according to the size and situation of the area to be served. We feel, in this health unit, that three months would not have been too long. If this had been possible, not only would there have been opportunity to explain the proposed set-up to interested individuals and groups—for which time had to be taken later when the demands were already heavy—but as well this period would have offered an opportunity to assess the area, its needs, assets, and potentialities. We are convinced of the merit of such a period of "pure" preparation since considerable benefit was derived from the medical director being able to come to the area one month prior to the date of establishment. The director of nursing services, who, since 1944, had been with the County School Health Service, was able, for a considerable period of time, to turn her energies to organizational work. The staff nurses came on duty one month after the date of the establishment of the unit. During that time basic policies were discussed and developed by the senior personnel and a plan for action arrived at.

From the point of view of the nursing staff it was decidedly advantageous that this time was available for preparation of the orientation period when the staff nurses arrived. At this time the policies formulated by the senior personnel were discussed and accepted by the nursing staff as a whole. Representatives from the various agencies operating within the county explained their work to the group. Nursing policies and techniques as applicable to a generalized program, and to our unit, were reviewed. Most important of all, perhaps, the staff became acquainted with one another and conscious of themselves as part of the health unit team. Much of the value of an orientation period is lost if it is not held at the opportune time. It is, of course, impossible to attempt one if the time for preparation is not available. A well-planned and well-timed orientation period sends the new staff members to their districts with an increased feeling of security.

It is true that the strength and rate of development of any new service depends, to a large extent, upon the foundations. It would almost seem better to wait for increased pressure, due to increased knowledge, from those for whom the service is devised, than to start the service and later spend considerable time selling the idea. That these foundations must be strong might be one condition governing the establishment of a health unit, or any public service for that matter.

Since it has never been the practice in establishing health units to include in the initial budget sufficient money for capital expenditures many problems are likely to arise. Boards of health are faced with the necessity of having to cut down on the number of personnel engaged so that those employed may be provided with the necessary equipment and a place or office from which to work. This results in the program being launched on a smaller scale than was anticipated by the public, which often brings down on the heads of the professional personnel a considerable amount of criticism. Since official programs are tax-supported it is not possible, to the same extent, to concentrate the work in one area so that a demonstration of an adequate program may be given and in this way influence a budget increase to ensure more personnel as soon as possible. Frustration is experienced by staff and public alike. Patience and

wisdom are required to face these problems and still visualize what an adequate public health program can mean. New health units would get off to a smoother start if capital expenditures could be included in the initial budget.

Realization on the part of the health unit personnel, that the public health program is but one aspect of the total plan influencing the community, ensures a greater degree of integration of the various public services and closer co-operation between the personnel employed in those agencies. The professional personnel working on a county basis is, in Simcoe County, endeavoring to gain a wider knowledge and a greater understanding of the community and the influences bearing upon it. This entails knowing as much as possible about the services of the various agencies involved—the social agencies; the library facilities; the public health program; the agricultural program; the educational programs, both formal and adult; the recreational program, etc. We are finding, through experience, that this organized study of the community, its needs and potentialities, is resulting in greater co-operation between the agencies and is leading to the development of a more integrated plan of action that is concerned with the community as a whole. Through this means many problems, which might arise through misunderstanding, a feeling of competition, or lack of knowledge of the aims and policies of other services, are being avoided.

This is but a brief discussion of a few of the challenging problems that accompany the organization of health units. It is important that in finding the answers to these difficulties we keep in mind the first purpose of a public health program, which is the enhancement of the health of the family. The health of any one family member is adequately dealt with only as we consider him in relation to the total family picture. Community health is the sum total of the health of the families living therein. Thus the program of a health unit is a challenge to each member of the staff and success can be achieved only when the total personnel work as a co-operative, co-ordinating team.

Nasal Hemorrhage

It may not be generally known that 95 out of a 100 nasal hemorrhages originate in the same area, which lies in the anterior cartilaginous portion of the nasal septum.

Why does bleeding occur in this place? There are two explanations for it. First, the occurrence of distended veins within the anterior portion of the cartilaginous nasal septum. The veins are so superficial and show such a vulnerability because of their thin walls, that relatively slight happenings, such as coughing, sneezing, blowing the nose, or bending the head, are sufficient to cause a bursting of a part of the dilated vessels. Once injured, these vessels cannot retract.

The second cause is a traumatic factor. The anterior portion of the nasal septum is, more than all other sections of the nasal cavity, exposed to traumatic insults, especially to the picking finger-nail. It injures the superficial veins and causes a hemorrhage. Blood clots in this part of the septum are frequent. The mucous membrane remains congested; secretion dries and sticks in this place. This condition tempts the owner to remove the dry secretion with the finger and produces new hemorrhages. It is a vicious circle.

The simplest therapy is to compress the bleeding area by inserting a hard pack of cotton into *each* nostril and pressing them against this anterior portion of the septum, by squeezing the nostrils together from outside with two fingers. The pack should be left on the bleeding side for 24 hours. In both types, after the bleeding has stopped temporarily, cauterization of the vessel has to follow in order to definitely cover the gap in the vessel's wall.

—*Rocky Mountain Medical Journal*

Private Duty Nursing

Lichen Planus

GERALDINE O'KANE *and* AGNES MCCAWELL

Average reading time — 7 min. 12 sec.

LICHEN PLANUS is an inflammatory disease of the skin and mucous membranes, the cause of which is unknown. It is characterized by a very itchy eruption of flat polygonal red or bluish-red papules that vary in size from a pinhead to that of a small pea. The centres of the papules may be depressed or resemble warts. These may be scaly or covered with a network of glistening white stria. The papules are usually arranged in patches separated by the natural lines of the skin, which they exaggerate. This eruption may appear on the buccal mucosa before the skin is involved.

The treatment of lichen planus includes tar baths and ointments, bismuth intramuscularly, arsenic by mouth or intravenous injection, and careful use of x-ray irradiation if necessary. Ointments containing phenol, menthol, ammoniated mercury, and zinc oxide may be used to relieve the itch and barbiturate sedation aids in keeping the patient comfortable. Although it is a protracted disease it eventually clears completely with or without treatment.

CASE HISTORY

On August 7, an extremely itchy red area appeared on the inner aspect of Miss Fry's feet. On August 14, she noticed a hard yellow layer forming on the surface and soles of her feet. This area was very itchy and became increasingly sore. Her ankles commenced to swell and small reddish-blue spots appeared scattered sparsely over her arms and legs, necessitating partial bed rest.

Miss O'Kane and Miss McCawell are instructors at the school of nursing, St. Joseph's Hospital, Hamilton, Ont.

On August 25, her condition resembled that of a rheumatic patient, as the feet were thickly calloused, sore and itchy. These excrescences were incised and a culture taken of the watery exudate. This was found to be staphylococcic in origin. The rash on her arms and legs was becoming more irritating. There was an elevation of temperature to 100°. Throughout the course of the disease her temperature ranged 99°-100°.

On September 6, Miss Fry was admitted to hospital and a new course of treatment was begun. This included complete bed rest and ultraviolet therapy daily to the point of producing erythema of her legs and back. Boracic solution compresses were applied to her feet every four hours for two days. September 8-15 her feet were kept wet with Dakin's solution continuously. Saratoga ointment was applied to the soles of her feet twice daily.

Medication consisted of sodium salicylate gr. V, t.i.d. and h.s. until September 14. On September 16 the dosage was increased to gr. XV, using the enteric coated sodium salicylate pills. These were continued until September 25 as there was still doubt as to the diagnosis. Salicylates are used specifically in treating rheumatic fever because of their analgesic and antipyretic action. Large doses are given because effect occurs only when the saturation point has been reached. Tablets containing codeine gr. ¼ were given t.i.d. and h.s. to relieve the intense itching. Nembutal gr. 1½ was administered at bedtime to relieve restlessness and sleeplessness. For four days it was found necessary to give this dosage of nembutal at 2:00 p.m. also. During this time liquor arsenicalis min. I was begun three times a day after meals. The dosage was increased by one minim daily until min. IV was being given three times a

day after meals. Then it was reduced at the same rate and was discontinued September 25.

Chronic skin diseases are frequently treated with arsenic preparations because of its effect on metabolism. It aids nutrition and growth and sometimes stimulates formation of blood.

On September 10, Sherman's (rheumatoid) mixed vaccine (No. 7) was administered subcutaneously beginning with min. III, increased by min. II every three days until min. XVI was reached. Then min. XVI were given every week.

Vitamin K, one tablet daily, was given from admission to maintain normal prothrombin time. Vitamin C 100 mg. was administered twice daily until September 14. This medication prevents the gums from becoming sore and bleeding. The dose must be repeated often because it is not stored in the tissues. After September 14, combined vitamins in capsule form were administered three times a day, one-half to one hour after meals. These are used in anorexia, anemia, undernourishment, and infection which may be due to a deficiency of vitamin C, especially when intake of the food is contraindicated. A special mouthwash was used three times a day before meals and at bedtime. This mouthwash was soothing and antiseptic in action. Three times a day a general body rub with a soothing ointment was given. When necessary, Benadryl capsules, two three times a day, were given for comfort.

A series of weekly injections of bismuth salicylate in oil (1½ cc. into the buttock muscle) was started during Miss Fry's stay in the hospital. These were discontinued after the fourth injection when a dark bluish line was noticed on her gums. This is a symptom of toxicity in those receiving bismuth.

On September 24 and October 1, x-ray treatments were applied to the anterior surface of her arms and the flexor surfaces of her legs.

Between her admission date and September 25 the purplish rash had spread to cover Miss Fry's entire body which became sore and itchy. Her mouth and throat were covered with a thick white coat which interfered greatly with eating. Her finger-nails and toe-nails became yellow, thick, and loose.

Miss Fry was given a diet rich in green vegetables. Until September 24 the fats and sweets were limited. It was quite difficult for her to masticate food due to the sores in her mouth and throat, with resultant loss of sense of taste.

The patient, always a moderate smoker, began to smoke almost continuously. Every effort was made to have this practice stopped but with the continued periods of restlessness and sleeplessness this proved quite a task for the nurse in charge. However, with the co-operation of her friends we did suceed in reducing the number to about four or five a day.

During the entire illness, periods of mental depression were common. Reading held her interest for a time but it was noted that she would frequently change to another article before completing the one commenced.

On October 5, Miss Fry was discharged from hospital. She remained an out-patient, receiving plenty of rest, in her own home for some time. Her body still displayed a rash and her appetite was poor. During November she lost considerable weight and became very listless. Gradually, during the latter part of November, the rash faded, leaving a densely mottled skin surface. The itchiness disappeared and her feet healed, although they remained very tender to touch. Miss Fry's mental attitude improved. She became more cheerful and interested in her surroundings and expressed a desire to return to work. She was still quite embarrassed with the color of her skin. Fortunately none of the blotches appeared on her face. She was able to resume her normal activities, with scarcely a trace of her rather rare condition.

Depression is thought to be commonly associated with the menopause. With normal women depressive moods do not reach pathologic proportions. If a woman undergoing menopause is unduly depressed she is either of a cyclothymic personality and has experienced depressive moods before or is a psychoneurotic of long standing, or is undergoing a reactive depression with circumstances having nothing to do with menopause.

Aux Infirmières Canadiennes-Françaises

Semaine de Santé à Lévis

CÉCILE DEMERS

Lecture — 8 min. 48 sec.

AU MOIS de juin dernier avait lieu à Lévis la Semaine de Santé, organisée en collaboration avec la Chambre de Commerce des Jeunes de Lévis et le Ministère de la Santé.

Cette Semaine de Santé n'était qu'une intensification du programme continuel d'éducation en hygiène, qui se poursuit depuis plus de deux ans dans le comté de Lévis. Après avoir jeté l'idée de l'organisation d'une Semaine de Santé à un organisme intéressé à l'avancement de l'hygiène publique, telle que la Chambre de Commerce, il était facile d'obtenir toute la collaboration possible.

Mlle Demers est éducatrice-hygiéniste avec l'Unité Sanitaire de Lévis, Qué.

L'objectif de cette Semaine de Santé était de rendre notre population plus consciente de nos problèmes d'hygiène et de l'importance de l'hygiène dans la vie de chaque individu, afin de prolonger sa vie, conserver sa santé, et éloigner la maladie.

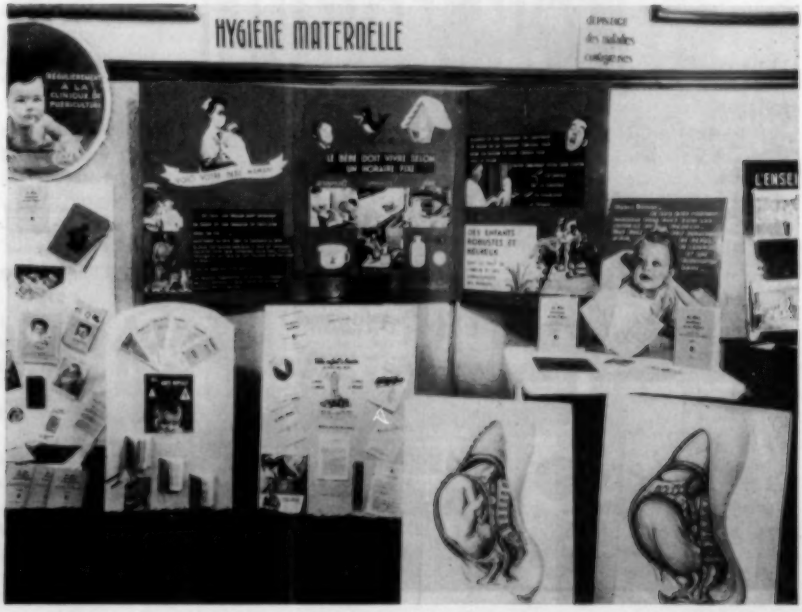
On ne peut faire l'éducation de quelqu'un malgré lui. Pour préparer le terrain à l'éducation populaire il est essentiel d'avoir la participation du public, ou le public ne se mettra à l'oeuvre que si l'on a d'abord éveillé son intérêt. Le programme d'éducation en hygiène mis en action, après avoir étudié la situation sanitaire du comté par nos statistiques de la mortalité et morbidité, nous avons constaté qu'il était urgent d'attaquer les problèmes les plus imminents: la

tuberculose, le cancer, l'hygiène maternelle et infantile, et les maladies vénériennes. Nos organisations sociales, intéressées au programme de l'éducation en hygiène, étudient ces divers problèmes de santé et, toujours avec leur collaboration, nous travaillons à résoudre ces problèmes.

Avec la Semaine de Santé, on a constaté chez tous beaucoup d'intérêt envers nos problèmes d'hygiène. Les problèmes furent exposés d'une manière aussi concrète que possible; les moyens d'enseignement visuels furent à tour de rôle employés. Le programme comportait des conférences avec films, des exhibits, et des démonstrations pratiques sur les problèmes de santé les plus urgents, tels que la tuberculose, le cancer, l'hygiène maternelle et infantile, l'hygiène alimentaire, et l'hygiène dentaire. Une bonne publicité avait préparé les voies à cette Semaine de Santé—des articles aux journaux et des causeries à la radio avaient mis l'attention du public en éveil pour profiter de cette semaine.

Chaque jour de la semaine avait au programme un sujet différent à l'étude. Après avoir assisté à une représentation de films sur un problème de santé quelconque, l'assistance pouvait visiter l'exhibit sur le même sujet et s'enrichir de plus de connaissances. Des infirmières se tenaient aux kiosques pour donner des explications et répondre aux questions des personnes avides de se renseigner. De la littérature était aussi distribuée aux personnes qui en faisaient la demande. Un exemplaire de chaque publication distribuée par le Ministère de la Santé et par la Compagnie Métropolitaine était exposé en évidence, afin que le public se renseigne davantage sur nos meilleures sources de documentation et continue ainsi de s'intéresser aux problèmes multiples de santé publique et individuelle. Combien n'ont-ils pas trouvé des moyens d'améliorer leur santé ou de résoudre leur problème de santé, en prenant connaissance de cette littérature? Il faut que toute publication soit distribuée à bon escient et à des personnes intéressées afin d'atteindre le but désiré.

Ce qui a le plus retenu l'attention du public fut l'exposition de la santé. Cette exposition était composée de différents kiosques sur divers problèmes de santé. Le but de cette exposition était de renseigner d'une



manière plus concrète, de faire réfléchir ou agir. Le public en général fut très intéressé à visiter les kiosques de la tuberculose et du cancer, tandis que l'hygiène maternelle attira une foule nombreuse de mamans et même de messieurs. Les questions posées furent nombreuses et très pratiques surtout de la part des personnes qui avaient assisté aux représentations de films sur l'hygiène maternelle. Le livre, "La Mère canadienne et son Enfant," distribué sur demande au kiosque, eut grande vogue.

Les jeunes gens et les messieurs furent particulièrement intéressés à visiter le kiosque traitant des maladies vénériennes. Là aussi des questions nombreuses furent posées et une demande considérable de littérature démontra l'intérêt manifesté pour se renseigner davantage sur un problème de santé aussi important. Les élèves de nos diverses institutions, accompagnés de leurs professeurs, étaient invités à visiter l'exposition de la santé. Des explications, sur chaque kiosque, leur furent données. L'intérêt des élèves et des professeurs était vraiment marqué. Il était très intéressant de répondre aux questions aussi variées que pratiques des différents groupes de visiteurs.

Avec cet exhibit nous avons obtenu une large part de notre objectif qui était de renseigner, de faire réfléchir ou agir. Après cette Semaine de Santé nous avons constaté une plus grande assistance aux cliniques anti-tuberculeuses et anti-vénériennes; nombre de jeunes gens se sont prévalus de l'examen du sang B.W., après en avoir compris les avantages.

Là ne s'arrête pas le travail de l'éducation en hygiène. Beaucoup a été obtenu du public de notre comté, depuis l'organisation du programme de l'enseignement en hygiène, mais il reste encore beaucoup à accomplir. Tant que le cancer et la tuberculose continueront à faire leurs ravages parmi notre population, tant que les maladies vénériennes se multiplieront, et que les taux de mortalité et de morbidité maternelle et infantile n'auront pas atteint le minimum, il reste encore beaucoup à réaliser. Le travail d'éducation est un travail de longue haleine et les résultats sont parfois lents, mais en autant que la collaboration du public nous est accordée, il y a lieu d'espérer des résultats durables.

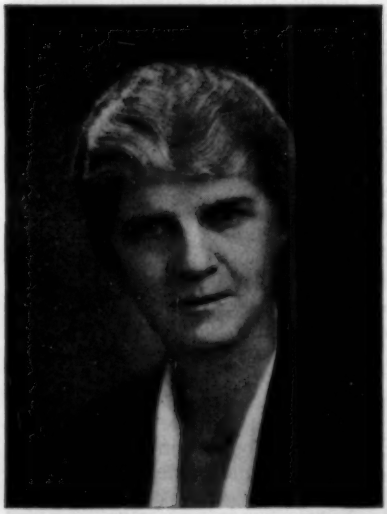
Espérons qu'avec cette Semaine de Santé notre population a compris une fois de plus que toutes les semaines de l'année devraient être une Semaine de Santé. Nous pourrons compter ainsi, dans un avenir rapproché, une population plus saine et plus forte.

Nursing Profiles

In every province in Canada the scores of friends and admirers of **E. Kathleen Russell** are delighted to learn of the latest honor that has been bestowed upon her. Long an ardent advocate of international understanding among nurses and very active in promoting this cordial relationship through the University of Toronto School of Nursing where she is the director, Miss Russell richly deserves the award of the Florence Nightingale Medal.

This Medal, which was instituted in 1912, is conferred biennially by the International Committee of the Red Cross Society upon nurses who have rendered conspicuous service in war or disaster, or who have made other notable contributions to the public good. Miss Russell is the sixth Canadian nurse to be given this decoration.

Born in Windsor, N.S., of Irish and Canadian parentage, Miss Russell secured her B.A. from the University of King's College in Nova Scotia before she entered the school for nurses of the Toronto General Hospital in 1915. When she graduated she was recipient of a scholarship which enabled her to study in the Department of Social Service at the University of Toronto. She also holds her B. Paed. from that university. At the sesquicentennial celebration of King's College in 1939, her *alma mater* conferred upon her the degree of D.C.L. (*honoris causa*) in recognition of her attainments in the field of nursing education.



Ashley & Crippen

E. KATHLEEN RUSSELL

After one year of supervisory experience with the Department of Public Health in Toronto, Miss Russell was appointed in 1920 as director of the newly established Department of Public Health Nursing at the University of Toronto. Seven years later, a new pattern of nursing education began to emerge with the development of the so-called "four-year course." Through her dynamic drive and clarity of vision, the present school of nursing came into being in 1933 assisted to a considerable degree by the Rockefeller Foundation.

Miss Russell's interest in nursing education has not been confined to one school. She was one of the first to advocate the making of a survey of nursing education in Canada and served as a member of the Joint Committee which guided the project some twenty years ago. Special recognition of her many contributions to nursing education in Canada was made in 1940 when Miss Russell was awarded the Mary Agnes Snively Medal by the Canadian Nurses' Association.

In 1942, the Canadian Red Cross Society appointed Miss Russell as their nursing consultant. No better choice could have been made of an interpreter of the aims and ideals of nursing to this very active lay group which carries on so many valuable enterprises for the betterment of the health of Canadians. It was because of Miss Russell's interest and salesmanship that the generous grant was made by the Canadian Red Cross Society for the development of the demonstration school of nursing in Windsor, Ont.

The nurses of Canada are proud of Miss Russell and rejoice that international recognition of such a high order has been conferred upon her.

Eleanor Scott Graham has been appointed the director of nursing and principal of the school of nursing at the Royal Columbian Hospital, New Westminster, B.C. A graduate of the Vancouver General Hospital, Miss Graham holds her B.A.Sc. degree from

the University of British Columbia and her Master of Science from the University of Chicago. She had engaged in public health nursing activities in several centres in British Columbia before she was appointed second assistant superintendent of the Victorian Order of Nurses for Canada. More recently she was health instructor at the Metropolitan School of Nursing, Windsor, Ont. Miss Graham has been active in nursing association work in both British Columbia and Ontario.

Sherick, Toronto

ELEANOR S. GRAHAM

Blanche Gertrude Herman, R.R.C., has resumed her duties as supervisor of nurses at the Western Division of the Montreal General Hospital which she had carried on so successfully from 1933 until her enlistment in the R.C.A.M.C. in 1941. Born in Lunenburg, N.S., Miss Herman graduated from the Montreal General Hospital in 1925. After a brief period in private duty nursing, she became head nurse on a private ward. She received her certificate in administration from the McGill School for Graduate Nurses in 1930 and went to the Royal Victoria Montreal Maternity Hospital for two years as assistant supervisor.

Miss Herman had a brilliant record of service during World War II. She went overseas as matron of No. 14 C.G.H., and accompanied this unit to Italy in 1943. That year she received the well-earned honor of the Royal Red Cross, first class. She was appointed senior principal matron for the

Adolphe, Montreal

BLANCHE G. HERMAN

R.C.A.M.C. in Italy and received mention in despatches for her devotion to duty.

Mildred Brogan, staff nurse with the Bell Telephone Company since December, 1947, has been named to the newly-created position of nursing supervisor for that company in the Montreal area. Among her tasks will be the direction of Bell nurses in their professional duties, including training, assigning work, and making certain that established medical procedures are carried out efficiently and correctly. She will supervise health education programs conducted by the nursing staff. Miss Brogan will also conduct research covering all phases of nursing and training procedures within the

Millar Studio, Montreal

MILDRED BROGAN

Rice, Montreal

BERTHA BIRCH

company and will act as liaison officer for the Bell nursing group in establishing contacts with other nursing groups in industry and teaching work.

Miss Brogan received her bachelor of arts degree from University of Montreal in 1939, graduating from the Montreal General Hospital School for Nurses in 1942. She took a course in teaching and supervision at the McGill School for Graduate Nurses in 1944 and returned to the teaching staff at M.G.H. until she entered industrial nursing.

In February, 1949, she was awarded a scholarship through the McGill School for Graduate Nurses to take a special course in industrial nursing at the University of Pittsburgh.

H. Berniece Lewis has taken over her new duties as director of nursing at the Public General Hospital, Chatham, Ont. Following her graduation from that hospital in 1939, Miss Lewis enrolled for post-graduate work at the University of Western Ontario. She accepted a position as assistant superintendent of nurses at Port Arthur General Hospital and later was superintendent of nurses at the Norfolk General Hospital in Simcoe. For the past three years she has been associated with the Public General Hospital, in the capacity of night supervisor for two years and latterly as obstetrical supervisor.

Last October, **Bertha Birch** severed her long connection with the Western Division of the Montreal General Hospital where she has been supervisor of nurses since 1941. Miss Birch's association with this hospital goes back for 40 years to the days when she arrived in Montreal from Chatham, Ont., her early home, to begin her training at the Western Hospital. All of her professional life has been spent here. For 19 years following graduation, Miss Birch was supervisor of the operating-room and assistant superintendent. When the Montreal General Hospital took over the premises as a private ward unit, Miss Birch became the night supervisor.

Her serene manner, keen sense of humor, and sincere appreciation of people's worth have endeared Miss Birch to all with whom she worked. She plans to reside in Montreal.

Anna Maloney has retired from her post as supervisor of the St. Elizabeth Visiting Nurses' Association in Hamilton, Ont., after 28 years of faithful service. She had been with the association since its inception and was devoted to the task of looking after the sick in their homes to whom she gave unstintingly of her time and skill. A beautifully illuminated address was presented to Miss Maloney in which was expressed the deep affection all her co-workers and patients felt for her.

Although the color of light usually has little or no effect upon clearness and quickness of seeing, it may have important psychological effects. Color nearest to daylight is considered desirable by many authorities. In the discrimination of colors such spectral quality is essential. Tungsten filament light is relatively deficient in green, blue, and violet radiations as compared with daylight. While this makes it unsuitable for color judgments it is satisfactory for ordinary purposes. Visual acuity (the ability to distinguish fine detail) is good under this light and the preponderance of yellow radiations makes it pleasing to most people. Some persons, however, are able to work longer with less fatigue under artificial light.

—*Selected*

Trends in Nursing

Average reading time — 5 min. 36 sec.

WHO Fights Tuberculosis

On July 30, 1949, the Expert Committee on Tuberculosis of the World Health Organization concluded a five-day session in Copenhagen during which it drew up a series of measures designed to strengthen health administrations in underdeveloped countries in the fight against tuberculosis. These measures, together with other recommendations, will be submitted to the 18-member WHO Executive Board, scheduled to meet in Geneva in January. They will then be fitted into overall plans that are being carried out by WHO to combat tuberculosis, which is still taking life from five million people every year.

Any comprehensive tuberculosis control scheme in countries with underdeveloped programs, the experts agreed, should start with a survey of the needs, resources, and attitudes of the people. Once this preliminary work is done, a central group directed by a leader could go on with tuberculosis control activities, devoting much of its time to the training of personnel to become members of field teams throughout the country as the program develops.

The importance of training public health personnel in underdeveloped areas to ensure nursing services to patients and to staff laboratories as well as dispensaries and hospitals, necessary for the isolation and treatment of infectious cases, was stressed repeatedly by the experts. They pointed out that WHO could be of great assistance in setting up centres to train local personnel in all phases of tuberculosis control work and to serve as demonstration centres for medical and auxiliary personnel of the area. The Committee further suggested that WHO might give useful information on certain types of hospitals which could be set up in a relatively rapid and economical way.

Health education was recognized by the Committee as an essential tool in tuberculosis control. It was urged that WHO should encourage national and international voluntary organizations to inform the public on all aspects of the tuberculosis program carried out in a particular country with the purpose of securing active support for it.

The value of tuberculin-testing and of BCG vaccination, as the only practical way known so far of producing specific resistance against tuberculosis, was reaffirmed by the Committee. Further, it was emphasized that BCG immunization could be fully effective only if used as a part of a general program in addition to the application of other available preventive measures. Mass vaccination with BCG was specially recommended for countries with high tuberculosis infection and mortality rates. However, it was pointed out at the same time that in all countries vaccination should be applied to individuals and groups for whom exposure to tuberculosis is likely.

In connection with BCG program the Committee heard a report on the work and plans of the research office which has been set up by WHO in Copenhagen to evaluate the results of tuberculin-testing and BCG vaccination now being carried out in the International Tuberculosis Campaign of the United Nations International Children's Emergency Fund, the Scandinavian Red Cross, and WHO. The experts agreed that results will be of great value to future planning of anti-tuberculosis campaigns on a world-wide basis.

Since the International Union Against Tuberculosis is expected to discuss the question of streptomycin at its next meeting in Copenhagen in 1950, the experts did not examine

this problem in detail. However, they did urge caution in the use of streptomycin, chiefly on the grounds that the drug is dangerous and that questions as to the type of patients who may benefit from it have not been fully answered yet.

The Committee warmly welcomed close co-operation with the League of Red Cross Societies and the International Union Against Tuberculosis. With regard to the latter, the Committee recommended that WHO, through its field staff, should encourage the development of voluntary anti-tuberculosis associations in countries where such societies do not yet exist and should promote their affiliation with the Union.

The Expert Committee on Tuberculosis is only one of the international groups which are to map details on plans adopted by the World Health Assembly a month ago in Rome for implementation in 1950 against numerous diseases and for better health throughout the world. The meeting in Copenhagen will be followed in the months to come by gatherings of experts on malaria, venereal diseases, maternal and child health, mental health, etc.—*Pan-American Sanitary Bureau Press Release*, Aug. 19, 1949.

Britain's National Health Service

The Minister has decided, on the advice of his medical advisers, to introduce the use of BCG vaccine on a limited and controlled scale, feeling that this form of immunization warrants trial.

It is proposed to offer BCG inoculations to all hospital nursing staffs. The general plan, agreed upon with the nursing organizations, will be to place information about BCG before the nurses and invite them in the light of this knowledge to make a decision whether or not they will be vaccinated.

The Ministry has prepared an explanatory leaflet for individual distribution and a full medical memorandum on the system in operation in Scandinavia will be made available. The responsibility for BCG vaccination, according to advice to the Minister, should rest on physicians with special knowledge and experience of tuberculosis or those especially chosen by chest physicians and trained in the technique of giving vaccine and recording results. The BCG, which is being imported by air from Copenhagen, will be provided free by the Ministry.

Records will be kept of nurses vaccinated and a study made over a considerable period of time to determine results.

BCG will also be available to chest physicians and other appropriate specialists who may wish to use it on their own medical responsibility. It will also be offered to medical students on the same general plan as outlined for hospital nurses.—THE MINISTRY OF HEALTH, Whitehall, S.W.1., Aug. 17, 1949.

Pioneering in Mental Health

Among all the groups who met in Geneva last summer the least noticed and perhaps the most important was the World Federation for Mental Health—the inter-professional body created in 1948 in London.

This inter-professional body was created for the express purpose of assisting the World Health Organization in fulfilling its functions with regard to mental health. Psychiatrists, psychoanalysts, social workers, anthropologists, penologists, nurses, clergymen, educators, and social scientists from 34 countries are represented in the Federation, membership in which is open to all professions interested in mental health.

What type of questions did the Federation discuss?

1. (a) The need for professional education and training in mental health work. (b) The need for public education in this field.
2. The mental health aspects of education with particular application to education in Germany.
3. The psychological aspects of religion and of international relations.

The theme chosen for research and investigation during the coming year

is "A study of the forces and conditions which raise men and women to positions of national and international leadership." Thirty-four countries and 300 groups will participate in this intensive research. The plan is first to concentrate on leadership in small communities and then move on to the national and international stage.

Observers from the WHO attended the Federation's meeting and were thus able to bring first-hand reports back to the WHO Expert Committee on Mental Health, which was beginning its meetings as the Federation adjourned. It was decided by the Expert Committee that, in the absence of adequate treatment facilities, the main effort should be directed toward preventive mental health work and technical training of medical personnel; that the World Health Organization should take the lead in developing in each region a centre for psychiatric studies. Such centres would teach the modern, dynamic conception of psychiatry to all members of the psychiatric team.

Such fields as alcoholism, drug addiction, crime prevention, etc., are included in the list of proposed activities. A first step only has been made in this pioneer effort but that first step is of great importance to the health of the world.—*World Health Organization, Newsletter*, Sept. 1949.

Orientation et Tendances en Nursing

L'Organisation Mondiale de Santé

La tuberculose fait encore cinq millions de victimes par année à travers le monde. Devant ce fait, l'O.M.S. a chargé un comité de spécialistes de déterminer les mesures à prendre et les recommandations à faire dans le but de combattre ce fléau. La tuberculose sévit avec plus de force dans les pays dont l'économie est moins développée. Le comité de spécialistes en tuberculose s'est réuni à Copenhague et a délibéré durant cinq jours. Le rapport sera soumis à l'O.M.S. lors de la réunion de janvier à Genève.

Voici quelques-unes des mesures et des recommandations du comité: Un programme de lutte contre la tuberculose dans un pays, où l'économie est moins développée, doit commencer par une enquête afin de connaître les besoins, les ressources, et les dispositions d'esprit de la population. Lorsque ce travail préliminaire est terminé un groupe initial, venant ordinairement d'un pays plus avancé, commence la lutte sous la conduite d'un directeur. Le gros du travail à ce stage est d'appuyer les services de santé existant déjà en formant un personnel entraîné parmi les habitants du pays. Lorsque la formation d'un groupe est terminé, chaque membre assume la direction d'une nouvelle équippe, qui reçoit, à son tour, une formation spéciale et va, à travers le pays, assurer le développement du programme à réaliser.

La formation du personnel dans ces pays peu avancés est d'une importance primordiale. Il faut bâtir une armature solide sur laquelle viendront s'appuyer tous les services de santé, dispensaires, hôpitaux, laboratoires, et tout le personnel requis pour isoler les contagieux et traiter les tuberculeux.

Une autre recommandation de ce comité de spécialistes est d'établir des centres de démonstrations dans divers régions du pays. L'on recommande que l'O.M.S. renseigne à ce sujet certains hôpitaux qui pourraient devenir à peu de frais des centres anti-tuberculeux.

Dans la lutte contre la tuberculose l'éducation du public est indispensable. Le comité recommande à cette fin d'inviter les organisations bénévoles, nationales et internationales, à renseigner le public sur tous les aspects de la lutte anti-tuberculose.

Le comité constate qu'à date le meilleur moyen pour combattre la tuberculose est la vaccination par le BCG. La vaccination par le BCG sur une grande échelle est recommandée dans les pays où le taux de l'infection et de la mortalité est élevé. Dans les pays moins éprouvés par la tuberculose, on doit également vacciner toutes les personnes exposées à contracter cette maladie.

L'O.M.S. doit évaluer les résultats obtenus par la vaccination BCG d'un grand nombre d'enfants, lesquels étaient sous la protection

de l'UNESCO. La Croix-Rouge et la Ligue Internationale Anti-Tuberculeuse prêteront leur concours.

LE SERVICE DE SANTÉ EN GRANDE-BRETAGNE

Dans ce pays le Ministère de la Santé offre à certains groupes la vaccination par le BCG. Cette décision du ministère fut prise sur la recommandation de conseillers au ministère.

L'on offre le BCG au personnel des hôpitaux, étudiantes infirmières, étudiants en médecin, et aux médecins spécialistes en tuberculose pulmonaire, qui pourront mettre le vaccin à la disposition de leur clientèle. On donnera des informations concernant le BCG et chacun restera libre d'accepter ou de refuser la vaccination. Des médecins spécialistes en tuberculose pulmonaire auront la responsabilité d'administrer le vaccin. Des dossiers de toutes les personnes vaccinées seront tenus et les cas revus à différents intervalles.

LA FÉDÉRATION MONDIALE D'HYGIÈNE MENTALE

Trente-quatre pays, membres de la fédération, assistaient à la réunion de l'été dernier. Tous les groupes professionnels intéressés en hygiène mentale étaient représentés.

Voici quelques-uns des points discutés lors de cette réunion: (1) Les besoins d'éducation et de formation professionnelle en hygiène mentale. Les besoins de renseigner le public en hygiène mentale. (2) Les différents aspects de l'hygiène mentale en éducation, avec l'application particulière à l'Allemagne. (3) Les aspects psychologiques des religions et des relations internationales.

Le travail de l'année portera sur l'étude des influences et des circonstances permettant aux hommes et aux femmes d'arriver à des postes, national et international, de commande.

Des spécialistes en hygiène mentale, envoyés par l'O.M.S. à titre d'observateurs à cette réunion, recommandèrent de diriger tous les efforts de l'organisation vers la prévention par l'hygiène mentale et vers la formation d'un personnel entraîné.

Il a été recommandé à l'O.M.S. de prendre le devant et de développer des centres d'étude en psychiatrie. Dans ces centres on enseignerait les conceptions modernes dynamiques de la psychiatrie à toute l'équipe psychiatrique, laquelle se compose de médecins, du psychologue, de l'infirmière, et de l'auxiliaire sociale en psychiatrie, etc. L'étude de l'alcoolisme, de la morphinomanie, et de la criminalité est aussi au programme.

La fédération n'en est qu'à ses débuts, mais déjà ce travail aura une heureuse influence sur la santé du monde.

Milk Between Meals

"Milk requires 3 to 3½ hours for complete gastric digestion . . . To give it at 10:30 (in school) and then send the child home for lunch at 12 violates the rules of physiology, dietetics, and common sense. Experience shows that the appetite for lunch may be much impaired."

For nearly 5 months, 59 convalescent children in a rheumatic fever rest home were given a 7-ounce glass of milk twice daily, one hour before meals. These before-meal feedings failed to elicit in any child any undesirable symptoms of anorexia, gastrointestinal distress, or decreased consumption of food. The added milk proved a true dietary supplement, well taken and well metabolized.

No evidence was found in these experiments to warrant advising the discontinuance of drinking milk between meals. The data indicated, on the contrary, that it is wise to make available such extra servings whenever there is need for improving a child's nutritional status or food intake.

—*Journal of Pediatrics*

Temper Tantrums

Temper tantrums are emotional outbursts to gain a point through a method found to be effective in the past. The obvious answer to this would be for parents never to be influenced in changing a decision by such behavior. They should meet the behavior firmly, adhering to the decision, banishing the child to his own room, or administering a spanking then and there. The essential point is to rob the tantrum of its effectiveness and to make it unpleasant. Spanking is not condemned by psychiatrists. However, it should not be the first resort; it should be done privately, not a "beating"; it should not be the father's first duty on coming home and getting the mother's report; and not be done in anger. If children feel secure and loved and learn early to respect the parent's prohibitions, spankings will be necessary very rarely.

Our Plan Unfolds

1950! What does it mean to you? Does it mean Convention Year? Is **June 26** your Red Letter Day? If so, you must be wondering what the Program Committee has in store for you. I will let you in on the secret. The Canadian Nurses' Association is planning for a bigger and better convention than ever before—the meeting *you* cannot afford to miss. There will be something for everybody—the private duty nurse, the faculty member, the supervisor or teacher, the general duty nurse, the public health nurse, the industrial nurse, the administrator in hospital or community and, that very important person, the student nurse.

Another little secret—the program is *yours*, it will be what *you* make it. About 150 people—Canadian nurses—will be taking part officially, but—the program is so planned that every single nurse will find opportunity to contribute. Get together and think through your problems and, in the words of that old forgotten song—"Pack up your troubles in your old kit bag" and come to Vancouver. Even if you are flying you will have room for your problems—the air lines will never notice their weight, and who is going to tell them? Not you surely!

Last month we reported to you that we had secured consultants for the staff education conference. It is not too late to send in problems within the area prescribed by this or any work conference. National headquarters will be glad to forward such problems to the consultants and they in turn will be pleased to know where your interests lie.

Long Term Patients

In view of the growing concern for the older patient and for those suffering from long crippling illnesses, you will be interested to learn that **Dr. Martin Cherkasky** of Montefiore Hospital, New York City, has consented to act as a consultant for the work conference, "Meeting the Total Needs of Long Term Patients." This topic provides food for thought on the part of every nurse in whatever capacity she may be serving patients in her community.

Evaluation and Accreditation

Another area of particular interest to special groups within the profession and to all who take a keen interest in nursing education is "Evaluation and Accreditation of Schools of Nursing." Faculty members and nursing school advisers have a particular concern with the status of nursing school programs. Concern, however, is of value only if it stimulates action. Are you sufficiently interested in the changing pattern to consider the need for an evaluation program? If so, you are probably asking, "Where can I secure advice? What do I need to know? When can I make a start? How is an evaluation program conducted?" The Program Committee of the Canadian Nurses' Association proposes to help you answer some of these questions, through the instrumentality of the aforementioned work conference.

Such outstanding people as **Sister Denise Lefebvre,** director of the school of nursing, Institut Marguerite d'Youville, Montreal; **Agnes Macleod,** director of nursing, Treatment Services, Department of Veterans Affairs, and chairman of the Educa-

tional Policy Committee, Canadian Nurses' Association; **Margaret Street,** secretary-registrar, Association of Nurses of the Province of Quebec, and **Sister Mary Claire,** director of nursing, St. Joseph's Hospital, Victoria, are prepared to act as consultants and to assist you in every possible manner to solve your problems.

Come prepared to pool your knowledge and your problems—to take an active part in discussions and to help formulate policies for the future. Early registration in this and in every work conference assures you of securing the place where you most want to be and will greatly assist the Program Committee.

You already know that the University of British Columbia has opened its doors to the Canadian Nurses' Association. There will be plenty of room for meetings and comfortable quarters for members and all at extremely reasonable rates. The following will give you some idea of how much money you will need to put aside each month—from now until the middle of June, 1950:

Accommodation per person, per day, payable in advance—$1.50.

Meals served on campus at very reasonable rates (tickets obtainable at registration desk).

See the October number of *The Canadian Nurse* for travel rates by air.

In Memoriam

Mabel Armstrong, who graduated from the Victoria Hospital, London, in 1923, died suddenly when preparing to go on duty on October 30, 1949. Miss Armstrong had engaged in private duty nursing for her entire professional career.

* * *

Mary Robena Fairweather, who secured her nursing training at Christ Church Hospital, Cincinnati, and who had given skilled care to the sick in and around Drayton, Ont., since 1910, died on October 16, 1949, in her 73rd year, after an illness lasting three years.

* * *

Mabel (Tangney) Kennedy, a graduate in 1912 of St. Michael's Hospital, Toronto, died on July 26, 1949, at the age of 60. Mrs. Kennedy had engaged in active nursing for five years prior to her marriage.

* * *

Teresa (Carey) Lee, a 1910 graduate of St. Michael's Hospital, Toronto, died on August 24, 1949, in her 64th year. Mrs. Lee served overseas during World War I.

* * *

Ethel (MacDonald) Linton, who was a graduate of the Calgary General Hospital in 1930, died in May, 1949. Mrs. Linton had been in poor health for about a year before her death. She was loved and respected by all the Calgary nurses.

Mary Mona (Ganderton) Mathewson, a graduate of the Edmonton General Hospital with the class of 1947, died suddenly in October, 1949, in Princeton, B.C., at the age of 25. Prior to her marriage four months before her death, Mrs. Mathewson was on the staff of the Princeton General Hospital.

* * *

Lucy Marie Parchem, who graduated in 1931 from Hotel Dieu Hospital, Windsor, Ont., died on August 3, 1949, in her 42nd year, following a long and exhausting illness. Miss Parchem spent most of her professional life as nursing director of the Webb Industrial Clinic in Detroit.

* * *

J. Ruth Reekie died in Toronto on October 25, 1949, following a prolonged illness. Miss Reekie was a former superintendent of nurses of the Guelph General Hospital and also of the Regina General Hospital. She had retired for some years because of ill health.

* * *

Dora Reid, who graduated from the Ottawa Civic Hospital in 1925, died at Gravenhurst, Ont., after an illness lasting many years.

* * *

Christina Sage, a graduate of Vernon Hospital, B.C., who had engaged in active

nursing in Lethbridge and Tranquille and who served overseas with the C.A.M.C. during World War I, died in Vancouver on October 30, 1949, at the age of 68.

* * *

Sister St. James, for many years the director of nurses' training at Hotel Dieu Hospital, Kingston, died suddenly while in the midst of her teaching duties on October 3, 1949.

* * *

Veronica Winterhalt, a graduate of St. Michael's Hospital, Toronto, who had worked as a public health nurse in Kitchener, Ont., for 30 years, died on November 13, 1949. She had retired two years ago.

Memorial Library

Miss Natsuye Inouye, who is president of the Japanese Midwives, Public Health Nurses and Clinical Nurses Association, and is also a member of the House of Councillors of the National Diet, inspects a volume from the library presented to the nurses of Japan by the War Memorial Committee of the Canadian Nurses' Association. It is called the Numo Memorial Library in honor of Miss Christine M. Numo, a public health nurse and teacher at St. Luke's General Hospital, now the Tokyo General Hospital, before the war. Miss Numo returned to the United States in 1941 and died there later. The books have been greatly appreciated by the Japanese nurses and are in constant use.

U.S. Army Photo

Student Nurses

Banti's Disease

EVELYN WILMS

Average reading time — 15 min. 12 sec.

THE TELEPHONE rang one evening when I was on duty and the admitting officer informed me that a patient was on her way up to one of our semi-private rooms. She was suffering from Banti's disease. I vaguely recalled hearing about this disease and associated it with some type of hemorrhage, but before I had time to find out anything more the ambulance stretcher arrived with Miss Cox.

She was a middle-aged woman, 42 years old, and of medium build. Her short, dark, curly hair framed a very pale and apprehensive face. As we tucked her into a warm bed I did not notice any signs of the external bleeding that I had expected. She did not appear to be seriously ill, judging by the manner in which she responded to my questions, but I knew that she had recently been very sick because she was upset, nervous, and shaky, and had a marked craving for ice-cold water. The interne soon arrived and examined her. He found that her blood pressure was fairly low, 116/70, her temperature elevated to 99⁶, her pulse 104 per minute, very rapid and weak, but her respirations were normal. He stated that there were no signs of shock and decided, as he hurried off, that it was safe to leave the treatment, which was a blood transfusion, till morning. Morphine sulphate gr. ¼ was given hypodermically for epigastric discomfort and as a sedative to quieten her nerves. Later, I entered the room again to see that Miss Cox was comfortable and warm and to check on her condition. I was disturbed to find that she had vomited approximately four ounces of clear fluid with intermingled strands of dark red blood. In an unconcerned manner she explained that she had vomited up about a basinful of dark red blood in the past two days. When she stated that these attacks had occurred periodically for over twenty years, it made me curious to find out what this Banti's disease was, and why they have not been able to stop these gastric hemorrhages.

Miss Wilms, a student nurse at Royal Jubilee Hospital, Victoria, was awarded the prize donated by the alumnae association for the best nursing care study.

DESCRIPTION

Banti's disease or syndrome, or splenic anemia, as it is often called, is regarded as a chronic condition of unknown origin, probably toxic and primary in the spleen. It is characterized by splenomegaly, anemia, leukopenia, a tendency to gastric hemorrhage, increased formation and destruction of blood cells, and later by cirrhotic changes with ascites and jaundice.

In 1883, Banti first observed that cirrhosis of the liver and splenic enlargement occurred together, and later described different phases in a detail which is accepted by no one today. That is the reason why "Banti's Disease" is so often referred to as "Banti's Syndrome"—a group of symptoms consisting of anemia, splenic enlargement, hemorrhages, and ultimate cirrhosis of the liver, which it is thought may be produced by a variety of causes.

Banti's theory was that the noxious agent, which is still unknown, was brought to the spleen by the splenic artery, either as a direct toxin or as

a substance which was there converted into a "splenotoxin." To date no known substance or micro-organism has been proven to play this etiologic role, but until more evidence is available it would seem a retrograde step to abandon the Banti concept entirely. In favor of the separate entity view is the considerable improvement that may follow splenectomy, the existence of splenomegaly before cirrhosis, and the occasional disappearance of an observed cirrhosis after splenectomy. However, it should be accepted that conditions such as cirrhosis of the liver, which produces a long-standing increase in pressure in the splenic or portal vein, can produce a practically indistinguishable picture.

Since there is no commonly accepted explanation of Banti's disease, let us then consider it as a syndrome associated with cirrhosis of the liver. A cirrhotic liver is one in which the liver cells are being replaced by fibrous tissue which causes atrophy, shrinking, and hardening. This condition does not allow free passage of blood through the portal veins so it is dammed back into the spleen and gastro-intestinal tract, with the result that these organs become the seat of chronic passive congestion—that is, they are stagnant with blood and so cannot function properly. Thus the characteristic splenomegaly is produced.

Due to this portal obstruction, portal hypertension develops and, because of its increased pressure, a portion of the blood in the gastric veins escapes through the esophageal veins. These veins become distended, forming esophageal varices, the thin walls of which often rupture. Thus hematemesis is experienced, usually increased by recurrent, profuse gastric hemorrhages. This prominent symptom is probably due to the greatly congested and enlarged spleen reversing the current of the gastric veins to the stomach, causing hemorrhage. In an acute attack these gastric hemorrhages, accompanied by sudden abdominal pain, pallor, weakness, and signs of collapse, may be fatal or preceded by an acute thrombosis causing death. In the chronic form, however, there are remissions (which are usually accompanied by pernicious anemia) and exacerbations of moderate attacks, varying within periods of from six months to five years, which may persist during an individual's normal life span with minor impairment of health. If these attacks get increasingly worse, the third stage, according to Banti, is ushered in by symptoms of cirrhosis, recurrent painless ascites with occasional jaundice and increased anemia and emaciation. Urobilin is present in increasing amounts in urine and feces. In the terminal stage, exhaustion, fever, and cardiorenal troubles are not uncommon. Death is due to hemorrhage of ruptured varices or an intercurrent infection.

History

Miss Cox was born in Glasgow, the eldest in a family of three children. They moved to Canada when she was about six years old so that her father could farm. This farm was sold after a few years and they built a home for retirement. Miss Cox has always lived with her father and mother. Her chronic disease has made her incapable of earning a living for herself by preventing her from holding a job for more than one or two years at a time. Her parents appear to be financially comfortable so it is convenient for Miss Cox to look after her parents and their home between her ill periods. She also does odd jobs such as tending children and working part-time at stores, mostly during the rush seasons.

Miss Cox always was healthy during her childhood and could not recall being sick for a day till she was nineteen. That summer she went camping after graduating from high school. It happened that as they were pitching the tent she suddenly jerked up to lift a pole. All at once she grew weak and felt nauseated. Soon she began to vomit profusely and was surprised and frightened to find the emesis a dark red in color. Returning to town immediately she underwent a careful examination by her family doctor who at that time diagnosed her condition as a possible Banti's disease judging by the

palpable, enlarged spleen. The hemorrhage stopped on its own accord in a few hours and after a few days in bed she felt perfectly well again.

Two years later, when she was twenty-one, Miss Cox experienced another gastric hemorrhage—this time more severe, probably from rupture of the gastric veins as well as the esophageal varices. Her family doctor advised a splenectomy rather than run the risk of leaving this condition untreated which could prove fatal in a few years. This operation was performed in 1928 when Miss Cox was twenty-two years old. Despite the operation Miss Cox has had attacks ever since, recurring within periods of from one to three years. It may be possible that the operation has prolonged her life. In this case, since there was no cure resulting, it appears that what was diagnosed as Banti's disease was actually a Banti's syndrome.

A cholecystectomy was performed about three years later which seems to indicate that severe complications were setting in, manifested by such signs as jaundice and urobilin in the stools and urine. This could suggest an early hypertrophy of the liver blocking off the bile ducts or simply a diseased gallbladder. At present, Miss Cox does not seem to be showing any untoward symptoms of gallbladder dysfunction, such as jaundice, clay stools, indigestion, or urobilin in the urine, although the urine has an unexplainable sweetish odor.

I was rather surprised when she revealed to me a symptom that I had never heard of before—bleeding from the umbilicus. Later, when studying this condition, I found that it was not an unusual sympton and resulted from atrophy of the liver. Due to the obstruction, the portal blood finds new channels and the superficial abdominal veins enlarge, notably about the umbilicus, forming the so-called "caput Medusae." This plexus of veins probably ruptures during the excessive retching in a severe attack and a slight red discharge is produced.

The typical onset of one of these attacks is very insidious. Miss Cox states she sometimes feels a fullness in her abdomen before hematemesis. Very often there is just a sudden nauesea followed by the vomiting. She then feels acutely ill, very weak, shaky and pale. If the hemorrhage is prolonged she is taken to the hospital for bed rest and blood transfusions. These are given to bring up the blood volume to normal in order to prevent shock, and to increase the low blood constituents such as the red blood cells, so important for hemoglobin content and oxygen concentration. During her period in the hospital after vomiting ceases she usually gets a severe headache which may be caused by a slight reaction to the blood transfusion. Otherwise she eats and sleeps well and regains her strength quickly. During this last year she has been hospitalized three times, each period being about two weeks. This might indicate a marked weakening of the muscles or veins or the onset of the terminal stages of this condition. This information on Miss Cox was obtained two days after her admission to the hospital when she was feeling much better.

Nursing Care

Adequate rest—particularly during the acute attack. The patient is then usually hospitalized as Miss Cox was. Anemia follows severe hemorrhage and in this condition absolute rest and freedom from any exertion is essential. The foot of the bed is elevated to lessen the anemia of the vital centres of the body. Added warmth is supplied in the form of extra wool blankets and hot water bottles to the extremities. Warm stimulating drinks are not given since there is bleeding from the gastro-intestinal tract. Patients are ambulatory but are required always to do light work that does not entail emotional or physical strain.

Proper care of the skin: Daily warm sponge baths are beneficial. If the anemia is severe, special care to the skin of the buttocks and heels is necessary to prevent formation of bedsores. Miss Cox's skin was carefully looked after and no broken areas were noticed—only a slight rash on the elbows due to friction of the sheets. Cocoa butter was applied to soften the rough, red skin and occasional applications of rubbing alcohol to prevent the skin from becoming too soft and thus breaking. Miss Cox has never forgotten the terrible bed-sore

that developed at the time of her splenectomy. Prophylactic measures consist of good skin cleansing, moving about to relieve pressure areas, and gentle massaging as well as medications applied to red areas, such as cocoa butter, alcohol, zinc oxide paste, B.F.I. powder, and so on. Fresh air is an important general health measure so the window was left open as long as possible. Chilling and drafts were avoided by placing a screen between the window and the bed.

Proper care of the mouth and teeth: Ordinary good oral hygiene after each meal, with special care to the mouth during the day, is indicated since these patients often have sores of the tongue, mouth, and pharynx. Miss Cox brushed her teeth after each meal, using her own tooth-paste, followed by an alkaline mouthwash. In the afternoon her mouth was swabbed with a special mouthwash, consisting of equal parts of boric acid solution, glycerin, and lemon juice. Her lips were covered with vaseline which prevented them from drying and cracking, due to dehydration. Sores were not noticed on Miss Cox's gums so this was more of a preventive and comfort measure.

Adequate diet is important with every patient. Miss Cox's diet consisted of fluids for the first two days gradually increasing to soft then light diets as tolerated. Foods easily assimilated and digested were given. Stimulants and coarse foods were avoided because of their irritation to the gastro-intestinal tract. Miss Cox's appetite was poor during the first few days but gradually increased as she began to feel better. Tact and gentle persuasion is often necessary in order to ensure an adequate intake of a balanced diet, but care must be taken not to overload the stomach.

Elimination: The bowels should be made to act daily. Miss Cox was given liquid petrolatum each night to soften the feces and Magnolax, a mild magnesium laxative, in the morning. She had no trouble with her bowels so elimination was easy to regulate. Often an enema is given to ensure "a good cleaning out." Miss Cox was voiding well since large quantities of fluids were given in the form of milk, broths, consommé, some fruit juices, after the hemorrhage stopped. This was done to avoid dehydration due to great blood loss and to dilute any toxins present since the kidneys may be impaired.

Administration of medicines: These were given as ordered, including blood transfusions. Miss Cox received the following drugs during her illness:

(a) Morphine sulphate ¼ when admitted. This hypnotic, a depressant of the central nervous system, was given as a sedative to relax and quieten the nerves and as an analgesic to relieve the epigastric pain. Morphine also helps to control bleeding by calming the patient, thus relaxing blood vessels which aids clotting.

(b) Demerol 50 mg. p.r.n. for discomfort. This white, colorless drug was given intramuscularly occasionally for epigastric discomfort in place of the morphine. It has an analgesic effect similar to morphine.

(c) Codeine gr. ½ was given hypodermically twice for severe headache. It is an alkaloid obtained from opium and is used for its analgesic, hypnotic, and sedative effects.

(d) Vitamin K, the anti-hemorrhagic vitamin complex which aids blood coagulation, was given, 1 cc. q.i.d. intramuscularly, starting the second day of admission, for three days. This probably prevented further bleeding from the ruptured blood vessels.

(e) Miss Cox received 500 cc. of whole blood intravenously each day for four days. These transfusions were very necessary as the blood morphology picture showed that the red blood count was only 1,640,000 when it should normally be between 4 and 5 million per cubic millimeter of blood. The hemoglobin was only 35%. After the fourth blood transfusion the blood morphology was done again. This showed a marked improvement. The red blood cells were 3,660,000 with only slight hypochromia and the hemoglobin was 69%. Blood was taken and retyped each day for the transfusions.

The nurse's responsibility during a transfusion is, firstly, to make sure the patient is receiving the blood designated

for him and when it is started to see that the blood flows through the donor set continuously at the prescribed rate. Secondly, to watch for symptoms of reaction such as headache, chilliness, rapid pulse rate, and a temperature increase of two or three degrees. The patient should always be kept warm, comfortable, and quiet, and if any of the above symptoms, indicating a reaction, are noticed, the transfusion is to be clamped off immediately and the physician notified at once. Often the first voiding after a transfusion is inspected for dark coloring due to gross hemoglobinuria which is indicative of an incompatible transfusion reaction.

Health Teaching

The importance of good general hygiene with particular attention to the skin and mouth is stressed. The patient must be taught the necessity of not overexerting and of adhering to treatments prescribed by the doctor, regarding diets, medicines, in order to keep as well as possible.

Mental Health

As in any chronic disease, patients may tend to be depressed because of their condition. Every effort should be made to keep them cheerful, by providing pleasant surroundings, entertainment such as books and magazines to read and the radio. They should be led to believe that they are not handicapped seriously, if at all, by directing their interests and possible talents into channels that best favor their condition.

Conclusion

This brings us to the end of our medical case study on Banti's disease —a chronic condition for which there is no accepted cause and no proven cure. This was a very interesting study of a medical disease even though it did not involve much actual nursing care. Miss Cox was discharged feeling well and happy and hoping that she would not have another attack soon. However, this seems to be wishful thinking because, looking over the history of this rare disease, we find that these hemorrhagic attacks progressively recur and finally end in death. The prognosis is poor.

References

1. Cecil, R. L. Text Book of Medicine. W. B. Saunders Co., Philadelphia.
2. Emerson & Taylor. Essentials of Medicine. J. B. Lippincott Co., Montreal.
3. Faddis & Hayman. Pharmacology for Nurses. J. B. Lippincott Co., Montreal.
4. Taber, C. W. Cyclopedic Medical Dictionary. F. A. Davis Co., Philadelphia.

Fact Sheet on Labor Relations

1. *When was the R.N.A.B.C. Labor Relations Program formulated?*

In the fall of 1945, by the Committee on Labor Relations. It was approved without dissent, by the general membership at the 1946 annual meeting of the Association. At the same time the appointment of a Select Committee on Labor Relations was approved, this small committee to implement the Labor Relations Program.

2. *Who pays for the Labor Relations Program?*

The members of the Association, through payment of annual registration fees, a portion of which is devoted to the Labor Relations Program.

3. *Is the program approved by the Canadian Nurses' Association?*

The C.N.A. approved the principle of collective bargaining in 1944 and recommended that nurses utilize the facilities of their professional organizations rather than those of other groups in endeavoring to obtain improved personnel practices.

4. *What facilities are offered by the R.N.A.B.C. to assist nurses in obtaining improved employment conditions?*

(a) Provincial Placement Service.

(b) Select Committee on Labor Relations.

(c) Any employee group of nurses (51% of whom are R.N.A.B.C. members) may name the Association as its bargaining au-

thority. The Association will then apply to the Labor Relations Board for certification.

5. *Who were appointed as members of the Select Committee?*

The registrar of the Association—as convener.

The chairman of the Committee on Labor Relations.

The chairman of the Committee on Legislation.

The director of the Provincial Placement Service.

6. *What are the functions of the Select Committee?*

(a) To help individual nurses or groups of nurses solve their own problems in a business-like manner.

(b) To participate in conferences with nurses and their employers.

(c) To act under certification, as above, as bargaining authority for employee groups of nurses.

7. *When should nurses seek the assistance of the Select Committee?*

Before relationships are strained. Individual nurses or the staff should attempt to solve their problems by first routing them through the proper channel—which is from the immediate supervisor to the director of nursing. If this procedure is ineffectual, assistance should be sought from the Select Committee. The aim of the Labor Relations Program is to prevent problems from becoming serious.

8. *What is the advantage of certification?*

In situations where the employer has been unwilling to give consideration to the wishes of the nurses, the employer is legally required to enter into negotiations with the certified bargaining authority.

9. *Who may use the services of the Select Committee?*

Any registered nurse or group of registered nurses in British Columbia.

10. *Will the members of the Select Committee go out to any part of the province to meet with nurses and employers?*

Yes.

11. *How may nurses obtain the assistance of the Select Committee?*

By writing, telephoning, or visiting the provincial office of the Registered Nurses' Association of British Columbia, 1101 Vancouver Block, Vancouver.

12. *Is the threat of mass resignation or strike used in seeking to obtain improvements in salaries and conditions of work?*

At the 1948 annual meeting of the Association the following resolution was adopted by the general membership:

"WHEREAS, The use of threats of mass resignations of nursing staffs to obtain objectives violates the principles of professional service and, in the opinion of the public, constitutes strike action; therefore be it

"*Resolved*, That the R.N.A.B.C. go on record as disapproving of such action by any registered nurse or group of registered nurses in this province."

13. *Has the R.N.A.B.C. outlined general recommendations concerning working conditions, salaries, etc.?*

Yes. Each year since 1945, in annual meeting, members of the Association have discussed and approved desirable recommended personnel practices for the coming year and copies are sent to hospitals, public health agencies, medical and hospital associations throughout the province as well as to R.N.A.B.C. members.

14. *What items are included in the recommended Personnel Practices?*

Recommendations regarding hours of work, statutory holidays, vacation, sick leave, residence, board and laundry, salaries, definitions of positions, marital status, permanency and temporary employment, staff health program, pension plans, employment contract, and a recommendation that the personnel practices be subjected to study annually.

15. *Where may copies of the revised recommended Personnel Practices be obtained?*

From the R.N.A.B.C. office.

16. *Is collective bargaining compatible with the professional status of nursing?*

Yes, since through it nurses can work together to promote their economic security without jeopardizing standards of professional practice.

Many parents feel that talking back must be ruthlessly suppressed. Impudence cannot be tolerated; however, many parents and teachers will not even allow a child a word in his own defence or an attempt to explain. Yet when they are offended they urge the child to stand up for himself. The importance to state his case, to assert his rights is too great to confuse it with "no talking back." Talking back, in the sense here defined, avoids intolerable frustration which results when the child is prohibited from saying anything about his feelings.

Book Reviews

Operating Room Technique, by Edythe L. Alexander, R.N. 765 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Illustrated. Price $11.00.

Reviewed by Mary Ogilvie Berry, Operating-Room Supervisor, Homoeopathic Hospital of Montreal.

Although each individual hospital has its standard procedures set up, the fundamental techniques are most clearly and concisely presented in this volume. Most textbooks fail to cover the many simple problems facing the student and young graduate interested in surgery. In the opening chapters, the supervisor will be interested in the plans for the teaching of students and helpful outline of general management.

The chapter dealing with the history of asepsis is informative and interesting and must have been compiled only after extensive research. It is most instructive. In Chapter 8, suturing material is discussed in detail and most valuable are the illustrations of instruments, with lists for different types of operations performed in the majority of operating-theatres, instructive explanation of the nomenclature, valuable descriptions of the surgeon's operative procedure, with accompanying medical illustrations clarifying each step followed.

This book should be included in all operating-room libraries and great credit is due Miss Alexander for her patience and for the hours devoted to providing valuable guidance to surgical nurses. After many years of experience, I found this book to be interesting and inspiring.

Tests and Measurements—Applied to Nursing Education, by Hyman Krakower, Ph.D. 179 pages. Published by G. P. Putnam's Sons, New York. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Price $3.85.

Reviewed by Murial Archibald, Statistical Worker, Canadian Nurses' Association.

"Tests and Measurements" is really a basic textbook for those interested in the formulation, preparation, etc., of tests and in the interpretation of data as applied to nursing education. It is a loose-leaf book which may prove useful when wishing to add to or take from its pages.

The text starts with the assumption that the reader knows little or nothing about its subject, and guides her with simple language and well-chosen examples one step at a time. At the end of every chapter are sufficient problems to make the learner familiar with the words and problems to which she has been introduced. Words and phrases such as "percentile graph," "mode," "median," "standard deviation," and "coefficient of correlation" will no longer be mysteries. However, this is not a book that can be read in a day but one that needs to be digested slowly and thoroughly.

Administrators, directors, teachers, and supervisors who have time, in a planned program of nursing education, will find it of inestimable value in student selection and student accomplishment. It would make an excellent guide for a course in "Tests and Measurements" in a program of supervisory staff education.

Pediatrics and the Emotional Needs of the Child, edited by Helen L. Witmer. 180 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1948. Price (in U.S.A.) $1.50.

Reviewed by Miriam L. Gibson, Instructor of Nurses, Hospital for Sick Children, Toronto.

This book is a discussion of the value of some psychiatric training for the pediatrician; the great need for more doctors to understand the emotional as well as the physical needs of a child. Up to the present time chief emphasis has been placed on the physical care and treatment. The question was asked as to whether there should be more child psychiatrists or should pediatricians be trained to meet the child's emotional needs. As this is only a report of a conference, the question is not answered. This book is of value in stimulating thought "in the hope that it may serve to strengthen in some slight degree the integrative forces in medicine."

Many interesting and enlightening points are brought out in this discussion. Common sense plays an important part in training both the pediatrician and the parents as shown by Dr. Spock's discussion:

"During the first year of life it takes a pretty disturbed mother to make a disturbed child. The baby enhances the mother's ego rather than challenges it. But it is easy for things to go wrong during the second year. Unfortunately, at this time the pediatric visits become less frequent. Also, the pediatrician finds himself poorly trained to handle the psychological problems that so frequently occur. Toilet-training conflicts develop during the second year because the baby now has an ego and begins to have feelings about bowel function."

This book would be of little value to the nurse and very definitely is not intended as a text. However, it is a very interesting and stimulating book to those who have had some background in pediatrics and psychiatry and it is essentially a book intended for the expert in these fields of medicine.

The Second Forty Years, by Edward J. Stieglitz, M.S., M.D., F.A.C.P. 317 pages. Distributed in Canada by Longmans, Green & Co., 215 Victoria St., Toronto 1. 1946. Illustrated. Price $1.98.

Reviewed by Jessie G. Morrison, Matron, Veterans' Home, Edmonton.

"The Second Forty Years" is a book that needed to be written. Since it has been written so effectively, it should be read by a large portion of the general reading public. Every age group, from the early twenties upward, would be benefitted by a thoughtful perusal of its pages.

In the early chapters, the author explains in a concise and lucid manner the process of aging biologically. The following chapters deal with the hazards inherent in aging, discussing the means by which they may be circumvented. It is worthy of note that the author stresses the fact that the ***means lie within the individual.*** He reiterates that longevity in itself is not enough, that it carries with it great responsibility—the responsibility of the individual to maintain health, independence, and so conduct his life that his maturing years will be fruitful and useful.

The place of the senior citizen in present-day business and industrial spheres is also discussed. Advantages and disadvantages attendant on his employment are pointed out. The advantages would appear to be in his favor.

The great problem of caring for our rapidly increasing, elderly, indigent population is placed before the reader in such a manner that it cannot avoid arresting attention. This was the author's purpose.

The material is well organized and ably presented. A summary at the end of each chapter is of great assistance in bringing pertinent facts into sharp focus. A list of recommended collateral reading is found at the conclusion and should be most worthwhile for those interested in pursuing this engrossing—and very personal—subject further.

Although the author intended this book to be a "popular" presentation, the many technical terms and phrases found throughout, would seem, to this reader, to put it out of that class of literature.

Blakiston's New Gould Medical Dictionary. Editors—H. W. Jones, M.D.; N. L. Hoerr, M.D.; A. Osol, Ph.D., with the co-operation of an Editorial Board and 80 contributors. 1294 pages. Published by Blakiston Publishers, 105 Bond St., Toronto 2. 252 illustrations on 45 plates—129 in color. 1949. Price—Textbook edition, $8.50; Thin paper edition, $10.75; DeLuxe edition, $13.50.

One of the most useful and comprehensive books to reach the *Journal* offices is this new, large dictionary. Backed by an imposing roster of 80 contributors, this book contains thousands of terms used in all branches of medicine and allied sciences, illustrations, and tables. Forty-five plates—some in color, some in black and white—include pictures and sketches of anatomical subjects, fractures, dislocations, micro-organisms, etc. Pronunciation of difficult words is made relatively simple by the use of syllable division and accent.

Any dictionary's value is dependent on the use that is made of it. The completeness of this volume's information should warrant it a place in every hospital. To permit easy access by students and graduates alike, it might even be included in the standard equipment of each ward.

The Hospital in Contemporary Life, edited by Nathaniel W. Faxon, M.D. 288 pages. Published by Harvard University Press, Cambridge, Mass. Canadian agents: S. J. Reginald Saunders & Co. Ltd., 84 Wellington St. W., Toronto 1. 1949. Price $6.25.

Reviewed by Bertha L. Pullen, Superintendent of Nurses, Winnipeg General Hospital.

This is a book of historical appreciation, showing the contributions and effects of economic, educational, social, and scientific progress on human betterment.

Although the various chapters seem irrelevant and deal with widely varying aspects of medical and hospital practice, education of the doctor, components of human suffering, growth of medicine and its relation to science and the place of the hospital in the social order, they all emphasize the prime factors of human relationships, spiritual attitudes in professional practice, and the importance of doctor-patient relationships based on the brotherhood of man.

The book accentuates the lag between the facilities for medical hospital care and society's demand for better community health; and the dangers of a premature and immature state medicine to the finest, fullest, and richest development of medical and hospital care for humanity.

This is not a textbook but a careful analysis of the imbalance between social needs and medical hospital development. It is interestingly written, very readable, and should be widely read by hospital administrators, doctors, and nurses.

Aids to Male Genito-Urinary Nursing, by John Sayer, S.R.N., D.N. 130 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1948. Illustrated. Price $1.25.

Reviewed by M. Mullen, formerly on the staff of the Royal Victoria Hospital, Montreal.

One emerges from a casual perusal of this book with a firm conviction that the author presents an invaluable text for students and post-graduate nurses covering the various points of knowledge regarding the anatomy and physiology of urological nursing.

The author has compiled a concise teaching and reference book, covering the pre- and post-operative treatments and nursing care of the patient with prostatism, nephritis, renal calculi, cystitis, and other urological symptoms. An excellent section is written on dietary treatment and the drugs to be used.

Of particular interest are the excellent illustrations of the delicate instruments and the various types of catheters which are used in described urological procedures and operations. The clear anatomical sketches shown throughout the book help us with a clearer mind to understand the knowledge fundamental to the study of urology.

This textbook, written mainly for the use of nurses, is in a pocketbook form, concise and easy to read, and will prove to be an ideal reference book to be carried about and referred to from time to time.

A Handbook for the Assistant Nurse, by Mary E. Swire, S.R.N., S.C.M. 308 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1949. Illustrated. Price $2.75.

This book is written as a handbook for the assistant nurse in England. It covers a wide field and many nurses may feel that it goes beyond what a nurse's assistant should be allowed to undertake. The material is not well organized and there is a vagueness or incompleteness about much of the information which lessens its value.

Some of the methods of procedure are anything but modern. Differences in customs and conditions and the difference in the scope of work of a nursing aide, apart from other factors, make it inapplicable for use in Canada.

This book would be of little value either as a handbook or on the shelves of a reference library for those in Canada engaged in assisting nurses in the care of the sick.

Nursing Sisters' Association

Members of the *London Unit* held their annual dinner at the Highland Golf Club in November. The president, Hilda Collier, of Westminster Hospital, welcomed the 39 nurses present. The vice-president, Bessie McKenzie, proposed the toast to the King.

The 18th annual meeting of the *Ottawa Unit* was held on Armistice Day at the Chelsea Club. Rev. John Stewart, former padre with the 3rd Division and at present rector of St. Margaret's Church, Eastview, was guest speaker at a luncheon which preceded the business meeting. The executive for 1950 includes: President, Evelyn Pepper; vice-presidents, D. Percy, Mrs. P. J. Philpott; secretary, F. I. Garnett, 310 Holmwood Ave.; treasurer, M. Phillips, 7 Carlotta St., Eastview; membership secretary, D. Dent, 54 Somerset St. W.; flower convener, A. McNicol; social conveners, Mrs. J. H. Stitt, J.

Attwood; councillors, V. Allen, E. Byrne, E. Schryer.

The *Vancouver Unit* now has a membership of about 150. The usual annual social affairs have been enjoyed, including an "After Five" party, a June picnic, and the Armistice dinner when 120 attended. B. McNair and E. M. Stewart from Hycroft have recently retired.

All members are looking forward to seeing many friends at the annual meeting of the association to be held in Vancouver in June.

Differential Diagnosis in Chest Pain

	Acute Coronary Occlusion	Angina Pectoris
Appearance of patient	Restless, ashen color, dyspnea, sweating. Shock may be present. Congestive failure may develop.	Patient quiet and immobile. Good color. No dyspnea. No sweating.
Pulse	Rapid and weak. Paroxysmal ventricular tachycardia present occasionally.	Normal.
Blood pressure	Usually falls to low level. Pulsus alternans may be observed.	Normal or elevated.
Temperature	Subnormal when first seen.	Normal.
Heart examination	Heart sounds weak and often rapid. Gallop rhythm is not uncommon. Friction may be audible if the area of infarction is on the anterior surface.	May be normal.
Duration of pain	Hours.	Few minutes.
Onset	At any time. Common during sleep.	Following exertion, excitement, or overeating.
Effect of nitrites	Pain not relieved. This drug may be harmful.	Quick relief usual.

Wm. G. Leaman *in* "Management of the Cardiac Patient" (J. B. Lippincott Co.)

Oxygen Tents

A properly managed oxygen tent furnishes a pleasant means of oxygen administration. The patient is unhampered by tubes or masks and he lies in a pleasantly cooled, humidified atmosphere, breathing the oxygen-enriched air. The tent is necessary for the administration of oxygen to small children and the older, non-co-operative patient, who usually do not tolerate the mask or intra-nasal catheter.

The oxygen tent will deliver an available oxygen concentration of 40 to 60% oxygen to the patient. A flow of 10 to 12 litres of oxygen per minute is necessary to furnish these concentrations in the inspired air. However, these concentrations are available only if the tent is managed correctly. If improperly managed, this form of therapy may be ineffectual and even dangerous.

It has been proved that the concentration

of oxygen in the inspired air must be at least 40% if oxygen therapy is to be effective. Yet many tests have shown the concentration of oxygen in the tent to be only 25 to 30%. This low concentration is usually due to a torn tent, improper adjustment of the canopy over the bed to ensure a tight fit, too frequent opening of the tent, or an inadequate oxygen flow.

—*Lancet*

Scabies Prophylaxis

With our present knowledge there should be little difficulty in treating and curing all cases of scabies as soon as these are diagnosed, but a great advance would be made if we could discover a method of scabies prophylaxis which would prevent infection from taking place.

I have little doubt that universal dipping with benzyl benzoate emulsion would prove completely successful in wiping out scabies. Unfortunately, there is available neither the benzyl benzoate nor the technical assistance to institute universal treatment.

We know that in human scabies the vast majority of the parasites are found on the hands and wrists and it was, therefore, thought that, instead of a universal program of "dipping," it might be possible to obtain satisfactory results by treating this restricted area of the body with benzyl benzoate. A great decrease in the incidence of scabies has occurred as a result of this treatment.

The conclusion which may be drawn from this work with school children is that frequent inspections by persons well used to recognizing scabies will serve to reduce the incidence of the disease very greatly, provided that cases, when found, are treated speedily and efficiently, and provided that the whole family of each case is also treated. Incidentally, the majority of the population seems still to rely on self-treatment with widely advertised "remedies" that are either quite useless or improperly used, so that no cure is produced and the spread of the disease continues.

One further point which emerges from this investigation is that it is very unlikely that children often contract scabies inside the school buildings. A statistical analysis of the incidence in the various classes reveals that cases were scattered entirely at random, without any significant concentration in any class. Furthermore, it was very rare, indeed, to find two cases of scabies in adjacent desks. There seems no doubt that scabies is caught out of school, mainly in the home, so that exclusion from school for this complaint is only essential because it is usually a necessary preliminary to ensuring proper treatment. If there is any delay in starting the treatment then the child is unnecessarily deprived of a period of education.

—*British Medical Journal*

Thumb-Sucking

Persistent thumb- or finger-sucking indicates that the child depends on this device for soothing his anxiety. He may not go to sleep without a finger in his mouth or do it automatically when growing sleepy. No steps should be taken in infancy beyond increasing the time at the breast or bottle and giving the baby more affection. Pulling his finger out of his mouth after he is asleep, pulling it out again if he puts it back, and continuing this consistently may stop the habit. The main concern is the possible resulting malocclusion and deformation of the palate. If no punishment is given for failure, but praise is freely given for success, the difficulty can rather quickly be brought under control. Bitter substances on the favorite finger, gloves, and metal devices are last-ditch measures after everything else has failed.

I have careful records of about 500 deathbeds, studied particularly with reference to the modes of death and the sensations of the dying . . . Ninety suffered bodily pain or distress of some sort or another, eleven showed mental apprehension, two positive terror, one expressed spiritual exaltation, one bitter remorse. The great majority gave no sign one way or the other; like birth, their death was a sleep and a forgetting.

—WILLIAM OSLER

Dr. Harvey Agnew Resigns

Dr. Harvey Agnew, executive secretary of the Canadian Hospital Council since its inception in 1931 and editor of *The Canadian Hospital*, has resigned to enter the consulting field. Dr. Agnew has joined the well-known hospital consulting firm of Neergaard and Craig, 41 East 42nd St., New York City, which will henceforth be known as Neergaard, Agnew and Craig.

Offices are being opened in Toronto and these will be under the direction of Dr. Agnew, who will continue as head of the course in hospital administration at the University of Toronto. Dr. Agnew will also continue on a part-time basis with the Canadian Hospital Council until next June.

Dr. Agnew organized the Department of Hospital Service of the Canadian Medical Association back in 1928 and continued as secretary of that department and as associate secretary of the Canadian Medical Association until 1946, at which time the work of the Department of Hospital Service was in large measure taken over by the Canadian Hospital Council.

A past president of the American Hospital Association, Dr. Agnew has served on a number of its councils and committees. He was one of the first selections for honorary fellowship in the American College of Hospital Administrators and is a member of the American Association of Hospital Consultants.

From his years of close contact with hospitals throughout Canada and the United States and his intimate knowledge of their problems, Dr. Agnew brings to his new association as consultant an experience rivalled by few in the practical handling of the many phases of hospital development, planning, organization, and administration.

A successor to Dr. Agnew has not as yet been selected by the Executive Committee of the Canadian Hospital Council. However, Mr. Murray Ross, of Edmonton, Alberta, has been named assistant secretary. Mr. Ross has been business manager and secretary-treasurer of the Royal Alexandra Hospital in Edmonton. He is a past president of the Associated Hospitals of Alberta, a trustee of the Alberta Blue Cross Plan, and a member of the American College of Hospital Administrators. Mr. Ross has had wide experience in executive work and brings to his new position an extensive knowledge of the problems of both large and small hospitals.

Tuberculosis Prevention

I spent an afternoon with the group that went through the Central Dispensary at Stockholm—the headquarters for Tuberculosis Prevention and "Follow-up." All newborn babies are given B.C.G. before leaving hospital and, if born outside of the hospital, the doctors are responsible for seeing that the baby has B.C.G. when between the age of seven and ten days. Children starting school are tuberculin tested and, if negative, are given B.C.G. Tuberculin is repeated when they leave school and B.C.G. given if necessary. No probationer is accepted in a school of nursing unless she shows positive tuberculin test. They claim they have practically no children with tuberculosis. A corps of nurses visits the homes of tuberculosis patients and, while they are doing a lot in the way of re-training patients who have been doing work that is not suitable for tuberculosis "cures" and these are helped to get established in suitable jobs, Sweden is still not satisfied with its rehabilitation program. Mass surveys have been carried on for several years. Their first round of the population is being completed and special surveys have been done in special occupational groups.

—AGNES CAMPBELL, *Superintendent of Nursing, Prince Albert Sanatorium, Sask.*, written following her trip to Sweden in June, 1949.

1949 INDEX

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1949 Index

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—*American Journal of Venereal Diseases*

Ontario

The following are recent staff changes with the Ontario Public Health Nursing Service:

Appointments: *Margaret Anderson* (Hamilton Gen. Hosp. and B.Sc.N., University of Western Ont.), formerly staff nurse, Wentworth County school health service, as senior public health nurse; *Alice Klugman* (Toronto Western Hosp. and U.W.O. certificate course), formerly staff nurse, Guelph board of health, as senior public health nurse; *Nora Cunningham* (St. Luke's Hosp., New York, and University of Toronto general course) Brant County health unit; *Emilia Longo* (St. Joseph's Hosp., Toronto, and U. of T. gen. course), formerly with Welland and district health unit, to Toronto Dept. of Public Health; *May Macartney* (Saskatoon City Hosp. and U. of T. gen. course) Leeds and Grenville health unit; *Patricia Marks* (Victoria Hosp., London, and U.W.O. cert. course) Elgin-St. Thomas health unit; *Joan Scott* (B.Sc.N., U. of T.) East York-Leaside health unit.

Leave of Absence: *Grace Joyce* from Windsor board of health to take advanced course in administration and supervision at U. of T.

Resignations: *Jeanne Bertrand* and *Jeanne Boudreau* from Prescott and Russell health unit; *Lillian Coles* and *Ethel Rutledge* from Guelph board of health; *Mrs. N. Delahunty* as public health nurse at Deep River; *Fernande Lefaive* from Sandwich West Town-

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ship; *Kathleen MacDonnell* from Sault Ste. Marie board of education; *Bertha Young* as public health nurse at Prescott.

Victorian Order of Nurses

The following are staff changes with the Victorian Order of Nurses for Canada:

Appointments—Burnaby, B.C.: *Joan Armstrong* (Halifax Infirmary) and *Beverley Carlyle* (St. Joseph's Hosp., Victoria). Calgary: *Elsie Lloyd* (Guy's Hosp., London, Eng., and Royal College of Nursing). Canso, N.S.: *Mary Fogarty* (St. Martha's Hosp., Antigonish) as nurse in charge. Halifax: *Elizabeth Harvie* (Children's Hosp., Halifax). London: *Margaret Gartley, B.Sc.N.* (Victoria Hosp., London, and University of Western Ontario public health course). Montreal: *Mildred Stacey* (Royal Victoria Hosp., Montreal). North Bay: *Isabelle Malleau* (Sacred Heart Hosp., Hull). St. Catharines: *Mary Marten* (Toronto Gen. Hosp.). Toronto: *Nancy-Ruth Fenn* (Toronto Western Hosp.), *Frances Hilliard, Marie Sauve, Betty Upper* (U. of T. School of Nursing), *Margaret Joyce* (Winnipeg Gen. Hosp.), *Helen Kennedy* (Women's College Hosp.), *Margaret Lee Kerr* (W.C.H. and U. of T. p.h.n. course), and *Norma Steeves* (R.V.H., Montreal). Windsor, Ont.: *Bertha Klassen* (Saskatoon City Hosp. and U. of T. p.h.n. course).

Re-appointments—Kirkland Lake, Ont.: *Marjorie Pexton.* Montreal: *Violet Dick.* Toronto: *Helen Gulliver, Cicely Hall, Bernice Seeds.*

Transfers—*Mary L. Clancy* from Toronto to Montreal; *Elizabeth Hicks* from Oshawa to York Township; *Catherine Jefferson* from Montreal to Toronto; *Phyllis Paisley* from Trenton to Brockville as nurse in charge; *Margaret Sams* from York Township to New Liskeard as nurse in charge; *Jean Webster* from Vancouver to Richmond, B.C., as nurse in charge.

Leave of Absence — *Catherine Ross* as nurse in charge at Richmond, B.C.

Resignations—*Mary Sehl, Maureen Seymour* as nurse in charge at Brockville, *Elizabeth Sharp* from North York, Ont., and *Phyllis Welling* from Winnipeg to take up other work; *Joyce McKay* from Hamilton—marriage; *Catherine Barrell* from Burnaby, B.C., and *Hattie Empey.*

News Notes

ALBERTA

LAMONT

Vera Alho, of Edmonton, was elected as president of the Public Hospital School of Nursing Alumnae Association at the 18th annual meeting and dinner. The vice-presidents are Mmes C. Wolff and L. Langford while Mrs. B. I. Love will continue to serve as secretary-treasurer. E. Ferguson is news editor while the executive includes: J. Graham, Mmes E. Bryks, J. D. Soper and J. L. Cleary. The association's honorary president is Mrs. A. E. Archer.

The secretary reported that, of the 265 nurses who have graduated from the school, 70 are paid-up members in the alumnae. Mrs. A. Southworth was appointed convener of the committee in charge of plans for a memorial to the late Dr. A. E. Archer, former superintendent of the hospital. A discussion took place concerning a book to record the history of the hospital from its inception to the 40th anniversary, to be celebrated in 1952. Mrs. Cleary will compile the material.

Joan Graham, past president, presided at the dinner and introduced Grace Douglas, one of the guest speakers. Miss Douglas, instructor at the hospital, who attended the I.C.N. Conference in Stockholm, gave an interesting talk on her trip, showing colored pictures of points of interest. Mrs. Cleary introduced Eve Henderson ("Helen Kent" of the air) who gave a colorful address on her introduction to radio and her career in social service on the airways. She also told of the Friendship Club and its activities, revealing the need it was filling in the lives of the older generation.

BRITISH COLUMBIA

Vancouver General Hospital

The members of the spring post-graduate class in O.R. technique and management are now located in Ontario and British Columbia. E. Curtis and P. Knowlton are with the County Hospital, Welland, Ont., and Joan Thompson has returned to the Royal Columbian Hospital, New Westminster. M. Hartley and S. Ross are on the V.G.H. O.R. staff.

The fall post-graduate class consists of: D. Bell and J. Bayer (Saskatoon City Hosp.); E. McBride (St. Boniface Hosp., Man.); A. Damery and A. McCulloch (Royal Jubilee Hosp.); I. Craig (R.C.H.); B. Jaffares (V.G.H.); D. Fujikawa (Herbert Reddy Memorial Hosp., Montreal).

VICTORIA

St. Joseph's Hospital was the scene of a recent meeting of Vancouver Island District when Sr. Mary Claire presided. The new district by-laws were approved and general business was handled. Dr. R. Fraser, president, Victoria division, Canadian Ar-

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thritis and Rheumatism Society, gave an informative talk on "The Problem of Arthritis in Canada." His lecture dealt with the organization of the group and the work of its lay and medical members. A social hour was later enjoyed under the direction of Victoria Chapter.

A program of lectures for graduate nurses on mental hygiene was recently sponsored by the Victoria Chapter. Topics included the following: "Life Begins" (film), Dr. U. P. Byrne, provincial director, Child Guidance Clinics; "Mental Mechanisms" (films), Dr. L. G. C. d'Easum, psychiatrist, Victoria Child Guidance Clinic; "Personality Structure" and "Good Mental Health," Dr. D. E. Alcorn, psychiatrist.

MANITOBA

WINNIPEG

Grace Hospital

Seven years of service in Santiago, Chile, are ahead for a Salvation Army lady—Capt. Hazel Williamson, R.N.—who has left for this South American centre, where she will open an out-patient clinic and day nursery.

A 1946 graduate, Capt. Williamson is a native of Vancouver and attended school in New Westminster. On completion of her studies, she enrolled in the William Booth Memorial College in Toronto to train as a Salvation Army officer. She has done field work for the Army in Vernon and Kelowna, B.C., and has also served as head of the surgical ward at the Vancouver Grace Hospital.

NEW BRUNSWICK

EDMUNDSTON

The Edmundston Chapter was hostess to the provincial association during the annual meeting in September. Executive members were entertained at luncheon at the home of Grace Stevens and at a late afternoon party at the home of Mrs. A. Titus following their business meetings.

At the close of the first day's session, the visiting nurses were entertained at tea by the Hotel Dieu Alumnae Association. The guests were received by Constance Fournier, J. Nadeau, and Mrs. B. Rice. During the afternoon Collette Fournier, a student nurse, sang several solos with R. Martin as her accompanist. Those in charge of arrangements were Mmes F. Landry, C. LaPorte and A. Titus, and Miss Stevens.

SAINT JOHN

B. Selfridge presided at a regular meeting of Saint John Chapter when the members heard an address by an officer of the Salvation Army who told of the Army and its work.

General Hospital

Margaret Godfrey, a S.J.G.H. graduate, is now executive director of the Cumberland Children's Aid Society, Amherst, N.S. With the R.C.A.M.C. for two years, Miss Godfrey has also served on the staff of the Shriners' Hospital for Crippled Children, Montreal.

St. Joseph's Hospital

M. Wallace, the president, presided at a regular meeting of the alumnae association when it was planned to send a Christmas food parcel to their "adopted" family in England.

Members of the alumnae were hostesses to the hospital nurses and their friends at an enjoyable bridge party when Miss Wallace and the convener for this event, Mrs. J. L. Mullaly, received the guests for 33 tables. The refreshment convener was M. Parsons, assisted in serving by Misses Morrisey, Carey, Power, Giddens, Ruland, Peterson, Morey, and Clinton. Prizes were won by Mmes Whalen, Doyle, Loughery, and Bridgeo, who received the lucky prize.

ST. STEPHEN

The annual meeting of St. Stephen Chapter was held at the home of Mrs H. Beck, preceded by a picnic supper arranged by Mmes C. Parks, H. Irving, and H. White. There were 37 members present. The president, Mrs. C. Dowling, conducted the business meeting when the annual report of the secretary showed an active year. The group participated in food and rummage sales, the sale of tickets on a blanket, the sending of parcels to English nurses, the placing of a wreath on the Cenotaph, as well as in many other endeavors.

NOVA SCOTIA

SYDNEY

Blanche Anderson, graduate of Royal Victoria Hospital, Montreal, and formerly on the staff of Ottawa Civic Hospital, is now an instructor at the school of nursing of the City Hospital.

Nine nurses recently received their diplomas at the graduation exercises of the City Hospital School of Nursing. The girls were addressed by Rev. Murray MacDonald of First United Church and Rev. A. A. Beaton of St. Theresa's Church. Mayor D. J. MacLean was chairman of the proceedings. Marcia Fitt, of New Waterford, who received four prizes, was valedictorian and reviewed their years' training under very efficient supervision. Awards were presented by Dr. H. R. Corbett, with Mrs. G. Martinello presenting gifts from the Senior Ladies Auxiliary. A. Martin, superintendent, presented the pins from the hospital after Mayor MacLean conferred the diplomas. The graduation class was addressed by Rev. E. B. N. Cochran of St. George's Church.

Mrs. R. MacKeen was convener for the annual banquet given by the alumnae association in honor of the 1949 class. The chairman for the evening was Hilda Boutillier. Miss Martin introduced the members of the class to the alumnae and the welcome from the hostess group was tendered them by Anne Urquhart. M. Fraser ably responded. The president of the Senior Ladies Auxiliary, Mrs. J. D. Matheson, proposed the toast to the nursing profession to which Mary Mac-

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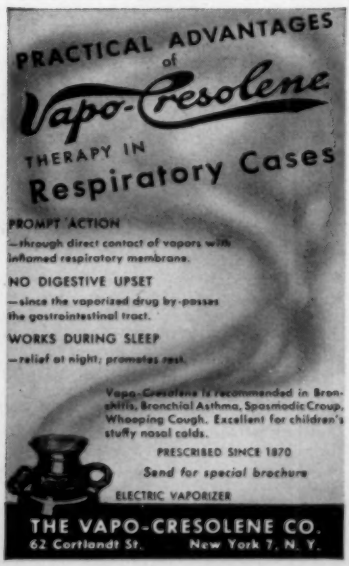
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Leod made a gracious reply. T. Cormier gave the class prophecy. The alumnae president, Mrs. C. Russell, expressed her thanks to all who had contributed in making the banquet a success. The highlight of the evening was Mrs. Alex LeDrew's talk on her recent trip to Sweden.

Another happy occasion for the graduates was the dance in their honor when the hostesses were the members of the hospital's Junior Auxiliary. There was an attendance of 150. Receiving with the graduates were: Miss Anderson, instructor of nurses; Mrs. R. Muggah, president of the Junior Auxiliary; Mmes Matheson and Russell. Mrs. F. Theuerkauf was refreshment convener.

ONTARIO

Districts 2 and 3

Brantford General Hospital

At a recent meeting of the alumnae association, Olive Plumstead and Marion Patterson gave a splendid report on their trip to Stockholm for the I.C.N. Conference. Souvenirs, snapshots, and scrapbooks did much to make their travels more vivid to those who were unable to go abroad.

Goderich

Thirty-nine members of the Community Nursing Registry attended a buffet supper when Madalene Baker, R.N.A.O. registry adviser, was present. Dr. Walter M. Little, Surg. Lieut., R.C.N. (R), was guest speaker and his topic—"Naval Medicine"—proved very interesting.

It was with regret that the resignation of Olive Webb, registrar, was received. She has held that position since the start of the registry four years ago. Her successor is Gwen Colborne.

District 4

Niagara Falls

At a recent meeting of Niagara Chapter, with B. Lousley, the chairman, presiding, about 40 members were present. Reports were read from the conveners of the various committees and the resignation of E. Clark, as vice-president, was noted with regret. Miss Clark has left the Welland County Hospital to go to Simcoe. M. Goldthorpe, of Fort Erie, has accepted the vice-presidency. E. Buchanan, industrial nurse with Ontario Paper Co. Ltd., Thorold, will take Mrs. Goldthorpe's place as convener of the General Nursing Section.

An interesting lecture and demonstration on "Liquid Air" was given by Mr. James Milne, chemical engineer with North American Cyanamid Ltd. The speaker was introduced by K. Pickard and thanked by P. Hobson. A social hour followed when Ruby Thompson, director of nurses, Greater Niagara Hospital, served refreshments. Anna Oram, of Welland, expressed the members' thanks to Miss Thompson and her assistants for their gracious hospitality.

District 8

Ottawa Civic Hospital

The annual tea and bazaar was recently held by the school of nursing alumnae association. The bazaar was opened by Mrs. H. G. Barber, president of the Ottawa branch of the Local Council of Women, of which the association is an affiliate. The proceeds were satisfactory and will be used for charity and bursary loan projects.

District 10

At a recent meeting of the district, a report of a fall meeting of the Board of Directors of the R.N.A.O. was given by the chairman, V. Weston. The annual meeting is scheduled for February 2 when a member from Geraldton will be requested to attend, expenses to be paid by the district.

Twenty-one members were present at a dinner meeting of the Public Health Section when F. Greenaway, public health nursing supervisor with the Ontario Department of Health, and E. Robertson, V.O.N. supervisor, were guests.

PRINCE EDWARD ISLAND

The quarterly meeting of the Association of Nurses of P.E.I. was held at Summerside at the beginning of November. The session opened with gatherings of the private duty, public health, institutional and school of nursing sections, followed by the general meeting. Sixty members attended the chicken dinner when Dr. Grant, of Summerside, spoke on "The Economics of Nursing."

QUEBEC

Montreal

Children's Memorial Hospital

Recent appointments to the staff include: M. Willsher, O.P.D. assistant (replacing E. Dumont); Rita Sabourin, O.P.D. staff nurse; Mrs. Burrows, operating-room; H. MacLean, head nurse, Ward G. (replacing M. Zinck); P. Abbott and Shirley Wilson, assistant staff nurses. I. Fairley has been granted a six-month leave of absence. C. Reashor will be acting O.R. supervisor.

SASKATCHEWAN

Qu'Appelle Valley

The local chapter recently held a successful Silver Tea, sale of home cooking, and bazaar at the nurses' residence, Fort San.

New members on the Fort San staff include: M. Fraser, B. Gillis, and M. Peterson (all recent graduates of Moose Jaw Providence Hospital), R. Kemper, and Mrs. H. Dunlop. M. Barney has transferred from Fort San to the San staff at Prince Albert. M. Parr is now in Oshawa, Ont., while C. Benton is on the staff at Redvers Hospital. A. Mitchell has returned from a two-month vacation in Ireland while M. Holman is still in Vienna.

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WINNIFRED GRIFFIN, Reg. N.

REGINA

General Hospital

E. James, president, S.R.N.A., recently attended the C.N.A. Executive meeting in Montreal. Miss James, V. Antonini, M. Matheson, and Mrs. M. Magdeline were present at the workshop on techniques at the Moose Jaw Providence Hospital. J. Findlay, G. Wilkie, and E. Hamilton are now on the staff at Bengough Union Hospital.

Grey Nuns' Hospital

A combination radio and phonograph was presented to the hospital solarium by the United Commercial Travellers in memory of the late Dr. Allan Blair. Following the writing of their R.N. exams, members of the September, 1949, graduating class were entertained at tea when the class of 1950 acted as hostesses. The graduates were given their school pins and diplomas. A fur fashion show was sponsored by the alumnae in the nurses' residence when many lovely furs were modelled by six student nurses.

P. Geesen, H. Grohs, K. Roth, and Sr. M. J. Tougas attended the workshop on techniques at the Moose Jaw Providence Hospital. It was reported to be an interesting session and it is planned to use the workshop technique for some of the problems of ward organization.

SASKATOON

City Hospital

The annual tea and sale of home cooking was held by the alumnae association at *H.M.C.S. Unicorn*. Proceeds of the tea will go towards parcels for nurses overseas. New members on the nursing staff include: P. Benning, R. Blisner, J. Cummine, S. Peterson, F. Swaby. Mary Nickel is now with a Red Cross outpost hospital in northern Ontario.

St. Paul's Hospital

The Sisters and students of the school of nursing wish to express their gratitude for sympathy received on the death of Doris Schmidt, one of their 3rd-year students.

Dr. D. M. Baltzan shared his holiday experiences when he gave an illustrated talk on his tour of Europe and the Holy Land. November 22, the Sisters' Feast Day, was celebrated by a grand concert given by the students. The 2nd-year students gave their annual Apron Tea. The Penny Carnival, sponsored by the Sodality, also took place. Mrs. A. L. Caldwell recently gave a series of lectures for the 3rd-year nurses on "How to Conduct a Meeting."

Saskatoon Sanatorium

New members on the staff include: F. H. Griffith and M. Moyer.

Infirmières demandées par

LA SOCIÉTÉ CANADIENNE DE LA CROIX-ROUGE

- Service général dans les avant-postes hospitaliers.
- Postes d'infirmières surveillantes et infirmières visiteuses dans les avant-postes infirmiers.
- Service de Transfusion.

Les infirmières, possédant un diplôme reconnu par l'Association des Infirmières du Canada, devront faire parvenir leur demande d'emploi à l'adresse suivante:

Directrice Nationale, Services du Nursing,
La Société Canadienne de la Croix-Rouge,
95 rue Wellesley, Toronto 5, Ontario, Canada

Positions Vacant

Advertising Rates — $5.00 for 3 lines or less; $1.00 for each additional line.

Vancouver General Hospital requires **General Staff Nurses.** Salary: $172 gross, including current Cost of Living Bonus. Extra premium for Evening or Night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

Nursing Instructor (qualified) for medical subjects & clinical teaching. Duties to commence early in 1950. R.N.A.B.C. salary schedule. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Operating-Room Nurse with special interest & experience in Eye, Ear, Nose & Throat work. Opportunity for advancement in new hospital. Apply Supt. of Nurses, Hospital for Sick Children, Toronto 2, Ont.

Graduate Nurse for Streptomycin Team. Also **Graduates for Floor Duty.** 5½ day wk. Full maintenance, hospitalization & Pension Plan available. Apply Director of Nursing, Freeport Sanatorium, Kitchener, Ont.

Operating-Room Nurses for large active Operating-Rooms in General Hospital, Winnipeg, Man. 48-hr. wk.; straight shift. Information concerning hours, salaries, etc., will be provided on receipt of application, stating preparation, experience & qualifications of nurse. Apply Supt. of Nurses.

Maternity Nurses—post-graduate training preferred, not required. 48-hr. wk.; straight shift. New Maternity Pavilion opening in near future. Information concerning salaries, sick time, etc., provided after application has been received, giving qualifications, years of experience, etc. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Registered Nurses for General Staff Duty for the Division of Tuberculosis Control required by British Columbia Civil Service—***Vancouver Unit:*** 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B. C. required. *Gross salary:* $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. ***Tranquille Unit:*** 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. *Gross salary:* $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting-rooms; recreational facilities. Maintenance deduction: Room $5.00, laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. Rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave 20 days per yr.—14 cumulative. Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses of respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

Public Health Nurses (2) for City of Fort William, Ont. Salary equivalent to larger centres, plus car allowance. Pension Plan. Transportation to city. Generalized program. Apply Medical Officer of Health, Health Dept., City Hall, Fort William, Ont.

Nursing Arts Instructor & Educational Director immediately. The hospital, located in capital city, is connected with large clinic & college which aids greatly in teaching students. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

EXPERIENCE IN PSYCHIATRIC NURSING

The University of Western Ontario School of Nursing, in co-operation with **Westminster Veterans' Hospital, London,** and other community agencies, will offer to Graduate Registered Nurses a programme of study and guided experience in **Psychiatric Nursing,** to commence ***in the early part of 1950.***

For further particulars write to:

The Dean, University of Western Ontario School of Nursing
London, Ont.

Asst. Night Supervisor for Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont. Apply, stating experience & qualifications, to Director of Nursing Services.

Night Supervisor & General Duty Nurses. Apply, stating qualifications & experience, to Supt., Queens General Hospital, Liverpool, N.S.

Staff Nurse for **Men's Medical Ward.** Also one for **Communicable Disease Ward.** Apply Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock & Toronto Psychiatric Hospital. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Graduate Nurses for General Floor Duty. Salary: $115 per mo. Full maintenance & laundry. $60 yearly increase up to 3 yrs. Apply, stating qualifications, Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Floor Duty Nurse. 8-hr. duty. Salary: $110. Full maintenance & laundry. Blue Cross hospitalization. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

General Duty Nurses. 8-hr. day, 6-day wk. Salary: $175 with 4 yearly increments. Apply, giving age, to Supt. of Nurses, Nanaimo Hospital, Nanaimo, B.C.

Registered Nurses. 8-hr. rotating shift. Cumulative sick leave. All statutory holidays after 3 mos. employment. Gross salary: $145 days; $150 evenings & nights. Residence facilities available. Apply A. D. Potts, Director of Nursing, General Hospital, Belleville, Ont.

Nurses—appeal to those who wish to contribute to the development of young Canadians. 65-bed hospital. Basic gross salary: $175 plus substantial bonus. Rotating shifts. Room, board & uniform laundry provided at $25 deduction. Staff housed in modern 4 & 6 single bedroom cottages on waterfront. Excellent opportunity to gain experience in Orthopedic & Pediatric Nursing. 26 miles from Victoria. Apply, in writing, giving date of graduation, training school, age & experience, Asst. Supt., Queen Alexandra Solarium for Crippled Children, Cobble Hill, V.I., B.C.

CANADIAN RED CROSS SOCIETY

invites applications for ***Administrative*** and ***Staff*** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

- The majority of opportunities are in **Outpost Services** in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia.
- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

WANTED

GENERAL DUTY NURSES

For 400-bed hospital. New Wing just opening. 8-hour day, 44-hour week. 10 statutory holidays. B.C. registration required.

Salary: $175 basic. Credit for past experience. Annual increments. ***Vacation:*** 28 days after 1 year. ***Sick Leave:*** 1½ days per month, cumulative.

Apply **Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.**

Asst. Supt. for 76-bed hospital by April. Apply, stating age, qualifications, experience & salary expected, Supt., Chipman Memorial Hospital, St. Stephen, N.B.

Operating-Room Supervisor for 350-bed General Hospital with Nursing School. Operating-Room occupies one floor of wing just opened; completely modern equipment. Applicant must have O.R. experience & recognized post-graduate course. Basic salary: $205 with consideration for experience. Apply, stating age, qualifications & experience, c/o Box 40, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurses for General Duty at General Hospital, Guelph, Ont. Initial gross salary: $150 per mo. plus laundry; $155 after 3 mos.; $165 after 1 yr. 8-hr. day, 6-day wk. Apply Director of Nursing.

Graduate Nurses for General Duty. Gross salary: $171 with bonus of $5.00 when registered in British Columbia. Annual increments. Statutory holidays. Good living accommodation & cafeteria service at reasonable cost. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, Vancouver Island, B.C.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurse for General Duty in 14-bed Paradise Hill Union Hospital. Salary: $140 per mo. plus full maintenance. 1 mo. vacation after 1 yr. service. Apply in writing to D. J. Wiens, Sec., Paradise Hill, Sask.

Nursing Instructors (2) urgently needed for University Nursing School at *Vellore, South India*—(1) A specialist in Obstetrics & Gynecology or Pediatrics. (2) A specialist in Anatomy & Physiology or Teaching of Nursing Arts. Nurses interested in these openings or any work at Vellore, correspond with Mrs. Hugh D. Taylor, 413 Wesley Bldgs., 299 Queen St. W., Toronto 2B, Ont.

Director of Bursing for 200-bed general hospital with school of nursing in attractive tourist town of 40,000. Program of reorganization and later expansion. *Duties:* organization and administration of nursing service and collaboration with school instructors. *Qualifications:* Registered nurse, preferably graduate from accredited university with 5 years successful supervisory experience. Leadership qualities. *Salary:* Dependent upon qualifications and experience. Apply to H. F. Garwood, superintendent, General Hospital, Niagara Falls, Ont.